

LIVED EXPERIENCE OF MUTUALITY IN A CARING MOMENT
BETWEEN THE NURSE AND PATIENT IN AN ACUTE CARE SETTING

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DEDICATION

I respectfully dedicate this scholarly work in honor
of the most esteemed nursing theorist, and my “guru”,

Jean Watson, PhD, RN, AHN-BC, FAAN

ABSTRACT

Therapeutic relationships are the foundation of nursing practice. Nurses can enhance these relationships through use of effective communication skills, their understanding of human behavior, and their insights into the caring relationship itself. More recently, nurses and nurse educators are looking to The Quality and Safety Education for Nurses (QSEN) initiative for new ways to narrow existing communication gaps between nurses and patients in order to provide safe care and improve clinical outcomes. It is thought that through nursing workforce development in establishing therapeutic relationships with patients, nurses can more accurately identify health problems, promote patient safety, and improve clinical outcomes (Sherwood, 2012) by reflecting on how they communicate with patients. The purpose of this dissertation is to explore the concept of Mutuality, as a social competency, in the context of exchanges between nurses and patients in an acute care setting. The findings of an exhaustive literature review of the concept of Mutuality in psychosocial and nursing-related databases are presented. A review of relevant contributions on this subject suggests the following research question: What are nurses' perceptions of Mutuality and its use in their interactions with patients? To address this question, Mutuality is viewed through the lens of Hagerty, Lynch-Sauer, Patusky, and Bouwsema's (1993), nursing Theory of Relatedness (THR) framework, and is used to inform and direct a qualitative descriptive phenomenological inquiry design. In-depth interviews with registered nurses on two medical-surgical units at Maui Memorial Medical Center in Wailuku, Hawai'i were conducted, the transcripts coded, and data analyzed according to Colaizzi's (1978), Nine-Step Comparative Data Analysis Method (Munhall, 1994; Streubert & Rinaldi-Carpenter, 2011), Categories (including the frequency of occurrence), theme clusters, and themes are presented and discussed as are nursing considerations and recommendations for future research with a focus on the patient in the nurse-patient therapeutic relationship.

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LIST OF ABBREVIATIONS

CITI	Collaborative Institutional Training Initiative
HIPAA	Health Insurance Portability and Accountability Act
HHSC	Hawai`i Health Systems Corporation
IOM	Institute of Medicine
IRB	Internal Review Board
KSAs	Knowledge, Skills, and Attitudes
MMMC	Maui Memorial Medical Center
MN	Maui North
MS	Maui South
PI	Principal Investigator
QSEN	Quality and Safety Education for Nurses
RN	Registered Nurse
RWJF	Robert Wood Johnson Foundation
UHM	University of Hawai`i at Mānoa
UHMC	University of Hawai`i Maui College

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CHAPTER 1

INTRODUCTION

The purpose of this introduction is to describe the evolution in nursing therapeutic relationships and to explore the role of the concept of Mutuality in that evolution. Today, fundamental changes occurring in caring-healing practice settings pose numerous challenges to nurses in providing safe care and improving clinical outcomes. One of those challenges is for nurses to transform the complex task of effectively and appropriately communicating when interacting with patients, even when interactions are momentary. Another challenge is to emancipate nurses from former rigid ideologies concerning ‘professional distance’ from patients so that nurses gain a better understanding of the patient’s health situation and what is needed to care for these patients (Munhall, 2007; Watson, 2012).

To address the aforementioned challenges concerning therapeutic relationships in acute care settings, a review of the Institute of Medicine’s (IOM) landmark study in 1999 entitled, *To Err Is Human: Building a Safer Health System*, was conducted. Recommendations made by the IOM researchers concerning patient-centered care and key communication strategies to integrate those recommendations into acute care nursing delivery and nursing curricula were examined (Dolansky & Moore, 2013; Hunt 2012; Sherwood, 2012; Sherwood & Zomorodi, 2014). An in-depth exploration of social and behavioral sciences literature was also conducted to analyze the paradigm of nurse-patient therapeutic relationships.

Problem

Nursing is an evolving profession and as a result, the ways nurses interact and effectively communicate with in-patients is evolving. Effective communication with in-patients appears contingent upon partnering with them through the use of intentionality, authenticity, negotiation, and coordination. The goal of employing these skills is so that patients’ health needs emerge and

are met. Hence, nurses are charged with establishing therapeutic relationships by engaging patients through the use of effective communication while bearing the responsibility of fulfilling a helper role.

Key to developing nursing knowledge concerning new ways to improve the efficacy of communication with in-patients is for researchers to explore unique social competencies [i.e. the ability to relate to people through connectedness] and characteristics [i.e. therapeutic use of self and mutuality] of nurses, which affect establishment of helping relationships (Benner, 1984; Hood, 2010; Northouse & Northouse, 1998; Shattell, 2005; Watson & Foster, 2008).

Sherwood (2012) suggests a human factor to consider is how nurses exact the tasks of relating to and communicating with patients. She states, “quality is an inherent approach to doing good work” and that “nurses come to work wanting to perform good work but they sometimes lack the preparation and tools or may work in systems where good work is not recognized or important” (p 16).

Day and Smith (2007) portend that nurses demonstrate effective communication when root causes of patient health problems are identified and addressed. This becomes evident when nurses ask, “What is the most important thing to do right now for this patient?” In answer to this, nursing researchers iterate that “When we ‘act for others’, we need to know both what the other wants and what we are willing to do and to have strategies for negotiating between those desires” (Shirley, 2007, as cited by Hood, 2010, p. 17).

To discover what patients want or need, nurses intentionally strive to connect with them through respect of personhood. As a result of this depth of connection, openness may be fostered and individualized nursing care enhanced (Chinn & Kramer, 2008; Chinn & Wheeler, 1985).

Significance of the Problem

Complex care situations unique to each in-patient require nurses to relate in unique ways to ensure competency in establishing a helpful relationship (Watson, 2012). Of concern is if the nurse-patient relationship takes the direction of adversely affecting a patient's health status as a result of ineffective communication. Additionally, misunderstandings of each other's intent can cause a breakdown in the nurse-patient relationship leading to uncertainty and estrangement (Ceci, 2006; Hood, 2010; Sheldon, Barrett, & Ellington, 2006). For instance, when conducting health assessments, it is beneficial to the patient that the nurse effectively relates to the patient, putting her or him at ease. This is important so that a bidirectional flow of information occurs. That is, the patient openly communicates information, needs, and expectations and the nurse freely provides information and services in an empathic manner based on the needs divulged (Anthony & Vidal, 2010; Grover, 2005; Small & Small, 2011).

Typical behavioral indicators of nurse competency in interpersonal communication related to patient-centered care are discussed in the literature. These include: (a) attempting to understand the situation from the patient's point of view, (b) predicting the patient's actions based on observations, (c) being genuinely interested in the cause of the patient's feelings, thoughts, and behaviors, and (d) effectively reading the patient's unspoken needs or concerns (Zhang, Luk, Arthur, & Wong, 2001).

Conversely, it is possible that when a therapeutic relationship is not established, the likelihood of misinterpretations or non-validated assumptions of 'what the matter is' (patient's health concern) may be made by the nurse. These misinterpretations and non-validated assumptions may have a negative impact on clinical outcomes, as erroneous data has been relied on when intervening (Elliot, Kanouse, Edwards, & Hilborne, 2007).

Tanner (2006) explains that levels of communication are influential in determining the effectiveness of relationships based on how nurses relate to patients. Therefore, nurses must evaluate the quality of interpersonal communication in terms of its benefit to patients' health and remain current in professional knowledge, by consistently evaluating the efficacy of communication through in-reflection (the nurse's ability to "read" the patient) and reflection-on-action (nursing practice experiences that contribute toward the nurse's knowledge and skill development).

Ways that nurses can establish and strengthen therapeutic relationships in order to promote patient safety and to improve clinical outcomes through communication were studied. This is important because a high level of dedication to doing a good job, and deliberately striving to relate to patients, may strengthen the quality of helping relationships (i.e. connectedness). To help sharpen the focus in studying related research, education, and clinical practice concerning how nurses relate to patients, a framework was necessary. The Theory of Human Relatedness was identified, analyzed, and selected as an appropriate framework.

Conceptual Model: Theory of Human Relatedness

The Theory of Human Relatedness (THR) framework initially grew out of the Hagerty, Lynch-Sauer, Patusky, and Bouwsema's (1993) clinical observations of psychiatric patients and the seeming demonstration of states of connectedness and disconnectedness (Hagerty & Patusky, 2003). As the framework evolved, the focus turned to social competency development and particular nursing skills needed to achieve what are termed, *States of Relatedness*. An understanding of the nature of relatedness underpins the framework with the idea that "nurses could intervene more quickly and appropriately with clients rather than relying only on traditional approaches" (Hagerty et al., 1993) of how to establish nurse-patient relationships.

Definition and Dimensions

Hagerty et al. (1993), discuss relatedness in THR as a primary, persistent, and pervasive aspect of human existence. Serving as the organizing construct for the theory, relatedness is defined here as an individual’s level of involvement with persons (self, others, groups, or society), objects, environments (natural or cultural), or spiritual entities (Hagerty et al., 1993; Hagerty & Patusky, 2003). All of the aforementioned are categorized as referents and are associated with a concurrent level of comfort or discomfort concerning that involvement.

Rooted in early attachment behaviors and patterns, relatedness is viewed as a functional behavioral system (Hagerty et al., 1993). Disruptions in relatedness can be caused by, and potentially contribute to, biological, psychological, social, and spiritual dis-ease. The two dimensions of relatedness are described as involvement-noninvolvement and comfort-discomfort, each of which exists on a continuum. When these two dimensions are fixed as intersecting axes on a grid (see Fig. 1) four *States of Relatedness* emerge: connectedness, disconnectedness, enmeshment, and parallelism (Hagerty et al., 1993; Hagerty & Patusky, 2003).

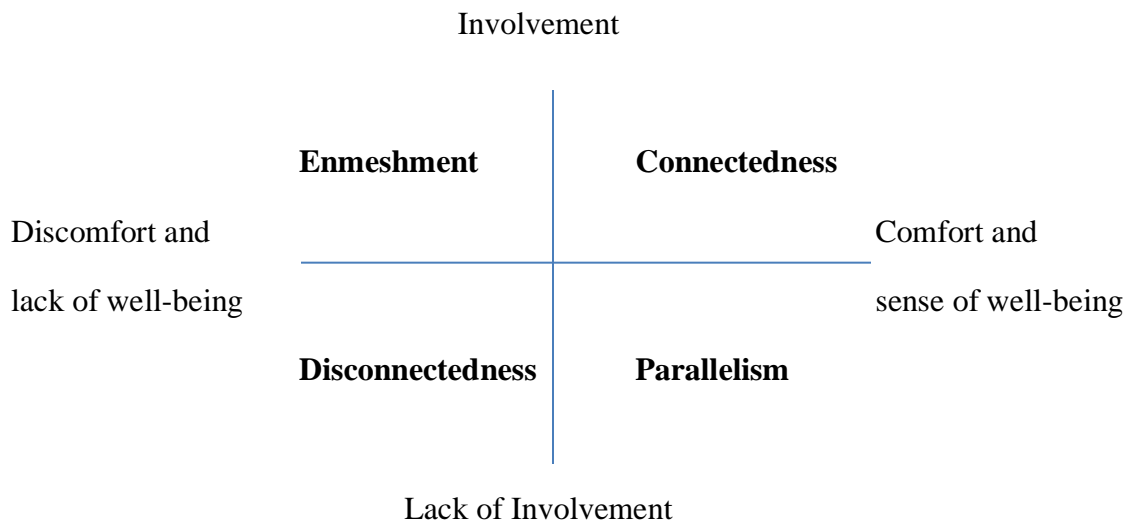


Figure 1. States of Relatedness

(Hagerty et al., 1993, p. 148)

Social Competencies

In addition to the described *States of Relatedness*, there are four major processes, or social competencies, involved in establishing and promoting these states. These social competencies are: (1) sense of belonging, (2) reciprocity, (3) mutuality, and (4) synchrony.

According to the authors and developers of THR, if *States of Relatedness* are viewed as a map (see Figure 1), then the social competencies might be viewed as contributors to these states (Hagerty et al., 1993; Hagerty et al., 1992; Hagerty & Patusky, 2003; Patusky, 2002).

Sense of belonging

Hagerty et al. (1992), portend that sense of belonging is the most developed conceptualization of the four social competencies to date (Hagerty et al., 1993; Hagerty & Patusky, 2003; Patusky, 2002; Strobbe, Hagerty, & Boyd, 2012). By definition, sense of belonging refers to “personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment” (Hagerty et al., 1992, p. 173).

Reciprocity

Reciprocity pertains to an individual’s perception that he or she is engaged in an “equitable alternating, interchange” (Hagerty et al., 1993, p. 294) with a referent, accompanied by a sense of complementariness. A common theme in descriptions of reciprocity is the quality and intensity of exchange (Finke, Light, & Kitko, 2008).

Mutuality

Specific to THR, mutuality is defined as “the experience of real or symbolic shared commonalities of visions, goals, sentiments, or characteristics, including shared acceptance of differences that validate the person’s world-view” (Hagerty et al., 1993, p. 294). Nelson (2000) postulates that at an intersection of two processes of pure experience, the patient’s and the nurse’s, Mutuality occurs. Hence, they participate nearly equally rather than nurse dominant.

This association to connectedness can be counted as belonging to two different lived experiences intersecting (Nelson, 2000) and that intersecting manifesting as Mutuality. Sahlsten, Larsson, Sjöström, Lindencrona, and Plos (2007) state Mutuality in negotiation “constitutes the dynamic nurse-patient interaction and that participation is founded on partnership, intimacy, and reciprocity” (p. 631). DeJesus (2009) identified interpersonal communication as an area of professional development and as relationship building and gaining Mutuality with clients.

Synchrony

Synchrony speaks to issues of rhythm, biological, psychological, social, and spiritual, and is defined as “a person’s experience of congruence with his or her internal rhythms and external interaction with persons, objects, groups or environments...[conveying] a sense of shared movement through time and space” (Hagerty et al., 1993, p. 294).

Summary

With the advent of caring-healing practice environments progressively dependent on partnerships, negotiation, and coordination, nurses are in a critical position to transform therapeutic relationships. These transformations can occur through new forms of communication patterns and authentic relationships with patients founded on Mutuality. In addition, improving a nurse’s perspective of the needs and expectations expressed through privileged access to patients’ health-related concerns (Watson, 1991; Watson & Foster, 2008) may impact clinical outcomes.

The designers of THR propose that a relationship exists between an individual’s competencies and her or his state of relatedness toward a specific referent, such that (1) higher levels of a sense of belonging, reciprocity, mutuality, and synchrony result in a greater sense of connectedness with that referent, and (2) lower levels of relatedness competencies result in a

sense of disconnectedness with respect to that referent (Hagerty et al., 1993; Hagerty, et al., 1992; Strobbe et al., 2012).

Therefore, Mutuality, as a social competency, was selected as the focus area for an in-depth review of the literature as it may impact patient safety and clinical outcomes. Additionally, it appears the nursing Theory of Human Relatedness (Hagerty et al., 1993) has the potential to serve as a unifying theory for these pursuits.

CHAPTER 2

INTRODUCTION

This chapter is organized into three main sections: (a) concept analysis, which includes the analysis method used and a brief translation of theoretical conceptualization, (b) literature review of the development and definitions of Mutuality as presented by major contributors in nursing and psychosocial sciences and, (c) current instruments that measure Mutuality. The limitations of these measures are presented as well as gaps identified in the study of the concept of Mutuality.

Concept Analysis

To examine the content related to the concept of Mutuality, a social competency in THR, a search of practice-based research, systematic reviews, literature reviews, and meta-analyses in the nursing and psychosocial sciences databases was conducted.

It was discovered that in 1997, researchers Curley and Henson had completed two separate reviews and analyses of the concept. Each researcher applied Walker and Avant's (1995) concept analysis method (Curley, 1997; Henson, 1997) for the discovery process. The perceived presence of Mutuality within clinician (nurse) and client caregiver (significant other) relationships was identified and the conventional assumptions of how the term has been used were explored. Following this initial review, it was determined that minimal knowledge exists in the nursing literature concerning Mutuality in nurse-patient therapeutic relationships.

Since it appeared there were only two existing systematic reviews of the concept in the literature, and they were outdated (1997), a broadened study using Rodgers and Knafl's (2000) steps in the Evolutionary Method of Concept Analysis was done. Rodgers and Knafl (2000) emphasize that this method of analysis is useful in studying a concept in a new situational context (i.e. care dyads) and discovering features of an underdeveloped concept

(e.g. descriptions, patterns, & relationships) (Munhall, 2007; Rodgers; 1989a; Sayers & deVries, 2008). A care dyad is defined as two agents who experience a real-time interaction (Hood, 2010; Varcarolis & Holter, 2010). The dyad is seen as an evolving creative relationship and is unique to practitioners who have expertise to facilitate health and healing within these interactions with patients (Hood, 2010; Varcarolis & Halter, 2010). In the context of this study, the agents are a nurse and a patient.

Knafl & Deatrick (2000) suggest, “Concepts shape how we think about the patients, families, and communities with whom we work. They direct our observations and our actions based on those observations” (as cited by Weaver & Mitcham, 2008, p. 182). Lastly, Raczaszek-Leonardi and Kelso (2008), describe in the study concerning synchronic analysis of symbols (mental constructs), “The two most obvious dynamics of interpersonal communication and dynamics of conceptual development are symbols” (p. 196).

Evolutionary Method of Concept Analysis

The steps of the Evolutionary Method are: (a) define the existing concept including its background and significance; (b) determine the essential elements of the concept from the nursing, psychological, and sociological literature; (c) develop a vernacular of terms to describe the concept; (d) present a historical perspective of the concept; (e) identify and name the attributes and antecedents of the term; (f) compare and contrast findings in the literature; (g) describe the implications for nursing practice; and, (h) formulate research question(s) from a review of the literature (Rodgers, 1989a; Rodgers & Knafl, 2000).

Literature Review

Nursing and psychosocial literature specific to nurse-patient dyads, as well as the fundamental aspects of the social competency, Mutuality, was searched for both conceptual writings and research pertaining to the concept. How the search was conducted is described as:

Search Strategies

A range of search methods was used to locate the studies and general descriptions of Mutuality. Firstly, general purpose electronic databases (specifically PsycINFO and PubMed [Medline]) expected to contain publications relevant to the topic of Mutuality were searched. Secondly, because Mutuality is a social concept, the search was expanded using a combination of keywords with a focus on therapeutic relationships in the following databases: CINAHL, Cochrane Library, CRISP RePORT, Google Scholar, PsychInfo, PubMed, and the Social Sciences Citation Index (SSCI).

These areas are important to explore in an effort to resolve the problem of a lack of clarity in descriptions of the nature of Mutuality and to frame an operational definition of the concept (Munhall, 2007). Underlying assumptions and attitudes about Mutuality were examined, as were its uses within nurse-patient care dyads.

Selection of Studies for Review

A review of literature was organized into two main sections: (a) a general search of the historical and theoretical conceptualizations of Mutuality and (b) a research-focused search of the development and definitions of Mutuality as presented by major contributors in the social disciplines in order to identify any gaps in the literature concerning definitions.

Keywords and grammatical variations of ‘therapeutic relationships’, ‘communicative processes’, ‘mutual process’, ‘mutuality’, ‘nurse-patient relationship’, ‘nurse-client relationship’, ‘reciprocity’, ‘partnership’, ‘alliance’, ‘relational understanding’, and ‘therapeutic communication’ were used. These terms were found throughout the aforementioned databases and represent the nature of therapeutic relationships and communication processes.

Inclusion Criteria

Inclusion criteria for this concept analysis were: (a) published in a peer-reviewed journal between 1981-2015, (b) published in English, (c) published with the use of primary research methodology (i.e. the authors of the study collected the data analyzed in the study) to begin an examination of at least one of the following: (i) the lived experience of Mutuality in exchanges between nurses and patients in an acute care setting, (ii) barriers to establishing Mutuality between nurses and patients, (iii) the attributes, antecedents, components of Mutuality, and, (iv) the assumption that Mutuality is a key factor in promoting patient safety and improving clinical outcomes.

Exclusion Criteria

The following dyads were excluded from the literature review: 1) family systems (e.g. partner-partner, parent-child, sexual partners); 2) caregiver-care recipient; 3) doctor-patient; 4) religiosity and/or faith between self and God; 5) relationships between objects or linguistic symbols; and, 6) physiological processes (i.e. histology mutual transformation). Also excluded were articles pertaining to *Change Theory*, the use of technology, work-related alliances, medical ethics, and prescriptive literature.

Relevant Article Yield

The initial search yielded 405 articles listed in the aforementioned databases. Of this yield, 65 documents were selected as relevant to the inclusion criteria. Relevant articles ranged from research studies (42) to discussion papers (23).

Search activities concentrated on the following areas:

- Integrative Reviews of the concept of Mutuality – N=3 (1997 [2], 2014 [1])

- Referent terminology associated with Mutuality (i.e. Caring, Connectedness, Effective Communication, Partnering, Being Sensitive, and Nurse-Patient Relationship)
- Caring Dyads
- Theory of Human Relatedness
- Operational definitions of Mutuality
- Psychometric instruments used to measure Mutuality in nurse-patient care dyads

The general discourse articles, in which the concept of Mutuality is discussed, concentrated on the following topics:

- Ethics of Mutuality
- Dyads
- Therapeutic relationships
- Relational caring, interpersonal communication, and patient-centered care

In May 2017, the aforementioned databases were surveyed for newly-published literature concerning Mutuality. One article entitled, *Mutuality in health care: Review, concept analysis, and ways forward* authored by Brown (2016), was identified. Institutional and professional constraints which limit the potential of mutuality within power relationships were identified and discussed.

Synthesis

Historical Account

The studies in nursing literature focus on two areas: nurses and clients and nurses and caregivers. Over the past 50 years, focus on the therapeutic relationship and communication between nurses and patients has produced evidence of Mutuality impacting the social skills associated with the long-lasting tradition of establishing therapeutic communication with patients

(Peplau, 1999). The aforementioned is an acculturation to systems theory within the nursing discipline which began in the 1960s and continues to evolve as a movement toward unitary consciousness with integral values exercises in a non-oppressive, open, free-flowing, and accepting relationship. Evident in the literature is that change is occurring in nurses expressing empathy, not sympathy toward patients.

The earliest reference to Mutuality in care dyads occurred in 1981, when King explained that “mutual participation” had been suggested as more effective in health care delivery than a “provider active and client passive” model (as cited by Henson, 1997, p. 77). Mutuality has been studied in the use of the concept and behaviors (language and actions) and for its disposition, or way of being. In support of these claims, social and psychological researchers describe Mutuality as a way of being respectful in relation to another (Buber, 1936, as cited by Henson, 1997), an element of healthy relationships (Erickson, 1968 as cited by Henson, 1997; Wynne, 1984 as cited by Henson, 1997), and a significant variable for caregivers and care receivers (Archbold, Stewart, Greenlick, & Harvath, 1990, abstract; Schumacher et al., 2008).

During the 1970s, “there was a controversy about whether or not nurses should form relationships with patients, some believing the nurse-patient relationships were ‘dangerous’” [to patients and nurses] (Shattell, 2004, p. 717). As discussed in Chapter 1, a later study of the Theory of Human Relatedness, Hagerty et al. (1993) defined Mutuality as “the experience of real or symbolic shared commonalities of visions, goals, sentiments are characteristics, including shared acceptance of differences, which validates the person’s worldview” (p. 208).

In 1997, two separate integrative reviews were conducted by Curley (1997) and Henson (1997). Embedded within these reviews are researchers’ exploration of the idea of mutual alliance in caregiver (significant other) and care recipients (patients) therapeutic relationships.

Both contributors suggest that nurses influence caregiver and care recipients in the context of healthcare situations, directly and indirectly, by establishing rapport with each counterpart.

Other researchers refer to Mutuality as a component of the communicative process in the psychosocial sciences literature. Likened to the term ‘consensuality’, Mutuality is considered a variable that affects dyadic care relationships (Deater-Deckard & O’Connor, 2000) which lies within the realm of interest in relationship factors. Those dyadic care relationships explored were specific to partner-partner (intimacy), parent-child, caregiver-recipient, corporation-patron, colleague-colleague, clinician/practitioner-client interactions (Piehler & Dishion, 2007).

Beck (2001) claims that a dyadic caring interaction can foster uplifting effects for persons involved. That is, feelings of being respected, of belonging, of personal growth and transformation among nurses who want to learn to care and to provide care (Ahlström & Wadensten, 2010; Auslander, Short, Succop, & Rosenthal, 2009; Beck, 2001; Curley, 1997; Henson, 1997; Kastle, Wilhelm, McKnight, Sheikh, & Zautra, 2010; Mendoza, 2012; Nelson, 2000).

Today, Cowling and Chinn (2001), suggest that in using a unitary perspective (oneness) lens “as a means of viewing, seeking, and envisioning human life and possibilities,” (p. 368) nurses can gain insight into a patient’s reality within the situated context of a health crisis. This includes unconditional acceptance of patients as they are.

Essential Elements of Mutuality (Aspects)

Jeon (2004) commends ‘the process of shaping mutuality’ as the central feature of a substantive theory of the working relationship within the nurse-caregiver dyad. The idea is that “shaping mutuality is an essential element of the development of the helpful relationship (and shared care relationship for/with the patient) between the nurse and caregiver characterized by

high levels of empathy, collaboration, equality, and interdependency” (p. 128). Jeon describes a “three-phase developmental process in the shaping of mutuality as: 1) lack of mutuality; 2) partial mutuality; and, 3) constructive mutuality” (pp. 129-131).

Mutuality has been referred to as a construct and is relationship-specific within a care dyad, which represents a type of bidirectional interaction (see Figure 2) between two people that is mutually responsive and reciprocal (equitable) (Deater-Deckard & O’Connor, 2000; Mårtenson & Fägersköld, 2007; Piehler & Dishion, 2007). This reference fits well with Ahlström and Wadensten’s (2010) description of the five sub-themes of the construct of Mutuality they created. The sub-themes are: 1) personal chemistry, 2) compassion for the persons in need of help and support, 3) the sharing of feelings, 4) solidarity, and 5) mutual responsibility and acceptance. Researchers, Briant and Freshwater (1998), posit that the “nurse-patient relationship is founded on the concept of mutuality” (p. 205) and is a co-creation of ‘mutual alliance’.

Researchers Curley (1997) and Henson (1997) claim that in the event when the nurse-patient feel connected, this connection becomes experiential for both. The diagram below has been adapted to depict ‘Nurse-Patient Mutuality’ (see Fig. 2) with “mid-point or balance” on the continuum to be “two extreme positions” (Henson, 1997, p. 77).



Figure 2. Nurse-Patient Mutuality

(Adapted from Henson, 1997, p. 77)

Additionally, Mutuality is considered an ‘autonomy-supportive’ approach or stance which conveys a belief in and respect of patients’ ability to take responsibility for their own lives. According to Zoffman and Kirkevold (2005), “...[Mutuality] has proven to be more reliable in facilitating self-empowerment, self-determination, and self-efficacy” (p. 760). Hence,

there may be improved problem-solving ability of patients regarding health when the nurse serves as a facilitator in interpersonal communication and regards patients as problem solvers. Through effective communication, the nurse explores and challenges patients' problem-solving strategies in connecting health issues with their lived experiences (Zoffman & Kirkevold, 2005).

The literature was searched in order to gain a better understanding of the aspects that inform the concept of Mutuality. The following six key aspects were discovered are briefly discussed below:

1. Equity and reciprocity
2. Use of essential humanness or personhood
3. Therapeutic use of self
4. Intentionality
5. Connectedness
6. Authentic caregiving

Equity and Reciprocity

Mutuality is a condition or quality of being mutual. It is also referred to as 'reciprocity' and 'mutual dependence' (<http://www.dictionary.com>). The origin of Mutuality was derived in ca. 1586 from the Middle French word *mutuel* and the Latin word *mutuus* to mean a reciprocal relationship between interdependent entities (objects or individuals or groups) (Webster's Ninth New Collegiate Dictionary, 1986). A hypernym of Mutuality is "a relation of mutual dependence or action or influence." A hyponym, or kind of Mutuality, is "the relation between two different entities that are interdependent and each gains/benefits from the other"

<http://www.audioenglish.net/dictionary/mutuality.html>.

Mutuality has been equated with 'reciprocity'. The word 'reciprocity' was derived in 1766 and is defined as "the quality or state of mutual dependence, action, or influence"

(Webster's Ninth New Collegiate Dictionary, 1986, p. 983). According to Finke et al. (2008), reciprocal responsiveness elicits a sense of 'being there' for another person, not just a physical presence, a nursing skill. This mutual flux (inter-subjectivity) is a dyadic process of thoughts, feelings, and activities which may potentiate gaining power and self-empowerment of each entity within the relationship (Ahlström & Wadensten, 2010; Auslander et al., 2009; Edwards, Peterson, & Davies, 2006; Kasle et al., 2010; Mendoza, 2012; Munhall, 2007; Nelson, 2000; Piehler & Dishion, 2007; Zoffman & Kirkevold, 2005). This is important in creating an autonomous and socially responsible nurse who becomes unconstrained in the practice environment (Munhall, 2007).

Also cited in the nursing and behavioral literature is that even equity in a connected relationship is "associated with equality in relationships, reciprocity, and having common interests, concerns, and aspirations" (Gallagher, 2010, p. 539). Whereas, mutual relating, when combined with positivism and responsiveness (Deatar-Deckard & O'Connor, 2000; Kasle et al., 2010), "is the reciprocal (equitable) process of developing mutual relationships premised on respect and reciprocal (equitable) understanding of each other's role and responsibilities culminating in an alliance" (McCann & Baker, 2001, p. 535). Piehler and Dishion (2007) explain that a greater degree of balance and reciprocity in interactions is achieved when cooperation, kindness, and appropriate social skills are present.

The seeming difference between reciprocity and Mutuality is that reciprocity is the simultaneous action of sharing whereas Mutuality is a state of relatedness in a reciprocal exchange.

Use of Essential Humanness or Personhood

Use of essential humanness, or personhood, is a critical part of the way nurses make themselves available to patients (Watson, 2012). Essential humanness, also referred to as

therapeutic use of self, can facilitate a turning point in a therapeutic relationship, which may facilitate patient openness. As a conscious experience of both participants, Mutuality evolves over time and allows for the evolution of each toward personal becoming (Henson, 1997; Kayser, Watson, & Andrade, 2007; Mendoza, 2012; Watson, 2012). However, Hagerty and Patusky (2003) suggest “nurses and patients do derive positive results from single short-term encounters that are necessitated by shortened hospital stays and are based on brief intervention techniques” (p. 146).

Therapeutic Use of Self

Therapeutic use of self has been previously explored conceptually and empirically in the social sciences databases. It is described as a dynamic developmental process within which shared feelings of intimacy, connection, respect of personhood, and understanding of another are key attributes. Through therapeutic use of self, nurses intentionally use their own personalities to establish relatedness, make nursing assessments, and structure interventions (Watson, 2012).

It is characteristic of nursing assessment that the very first connection between a nurse and a patient is meant to establish an understanding that the nurse is safe, a confidante, reliable, consistent, and that the relationship will be conducted within appropriate and clear boundaries (Travelbee, 1971). Another consideration pertaining to the use of self is that interdependence and influence in the relationships with others and a view of self becomes transformative (Hedelin & Jonsson, 2003).

Another characteristic of the aspect of therapeutic use of self is therapeutic communication. Therapeutic communication is a common topic of interest within the nursing discipline. DeJesus (2009) identified interpersonal communication as important for professional development. Hood (2010) states “when the nurse is deliberate and purposeful in establishing a level of communication with a client which promotes client openness (i.e. disclosing

information, needs, & expectations) the client's health needs are more likely to be met" (p. 471). Implicit is that Mutuality in communication must exist between nurse-client and may serve as a catalyst to ease client openness. In turn, it may promote reflection practices, gaining insight, and consciousness-raising of nurses concerning patients' health needs.

Finally, it is thought that how skilled nurses foster free-flowing verbal and non-verbal exchanges with patients makes a difference in establishing a helpful relationship, rather than formal, forced, or mechanical exchanges (Watson & Foster, 2008; Watson & Smith, 2001).

Intentionality

According to Smith (2011), manifesting intention is defined as creating, holding, and expressing thoughts, images, feelings, beliefs, desires, and will in action. These actions affirm possibilities for promoting health and well-being. Deliberateness reflects consciousness, "a meaningful energetic blueprint for transformation" (as cited by Cowling, Smith, & Watson, 2008, p. E46). This approach is important for gaining knowledge concerning development of nurse 'being-ness'. Specifically, manifesting intention is critical since presence, resonance, sensitivity, and mindfulness progress into an evolving pattern of a nurse and patient therapeutic process. This aspect of relational being-ness holds Mutuality within the nurse-patient relationship as central to authentic caring (Falk-Rafael, 2006).

Connectedness

Mutuality is labeled a determinant of connectedness within these relationships wherein each participant in the interaction becomes a counterpart in order for a sense of connectedness to happen (DeJesus, 2009; Eaton & Tinsley, 1999; Varcarolis & Halter, 2010; Weaver & Mitcham, 2008).

Researchers McCann & Baker (2001) describe Mutuality as a 'connected relationship' characterized by the qualities of openness, self-disclosure, trust, and friendliness. Miller (2008)

contends that finding meaningful connectedness helps human beings to encounter all of the vulnerability and risk faced in trying to “change and grow” (p. 114) and stresses “when mutuality is present, it does not mean that sameness or even equality occurs” (p. 115). Rather, what is encompassed within a connected relationship (e.g. qualities such as openness, self-disclosure, trust, & friendliness) (McCann & Baker, 2001) are reciprocal interactions and sharing of feelings like togetherness and equality with the parties simply “fitting each other” (Mårtenson & Fägersköld, 2007, p. 42).

Authentic Caregiving

Authentic caregiving is transformative and is built and sustained by nursing actions that develop Mutuality (Simone, Savini, Torino, Vellone, & Alvaro, 2014; Watson, 1999). One example is appropriate emotional vulnerability with patients. McCann and Baker (2001) surmise that such vulnerability entails building interpersonal relationships, which require an affinity for people, positive regard, wanting to get to know individuals, and the ability to engage freely in informal conversation.

Attributes (Characteristics/Qualities/Traits)

Attributes of a concept are “extracted from reality expressed in some form and utilized for some common purpose” (Rodgers, 1989a as cited by Rodgers & Knafl, 2000, p. 33) or commonality.

Curley (1997) describes Mutuality, not as a concept, but as an intrinsic attribute in the nurse-patient relationship. She posits that Mutuality is a quality of ‘relatedness’ and concludes that the dynamic nature of the nurse-patient interaction fosters mutual participation in discovering a unique set of patterned responses influencing choices and decisions. That is, exchanges occurring between two people who have a common goal or shared purpose.

While not always equal in power-sharing, the interactions are mutating, changing, and synchronous patterns of give-and-take, which facilitates movement toward a shared purpose. This manner of relating evolves as a sense of joint-ness and mutual satisfaction develop and may be of benefit to nurses gaining insights into patients' experiences of their health problems (Kayser et al., 2007; Mendoza, 2012).

Henson (1997) concludes Mutuality is one mode of relating to patients in a manner that facilitates active involvement between nurses and patients. During the course of being involved, counterparts "are effectively working toward mutually identified goals" (p. 78) by not only sharing an experience, but by participating as fully as possible and with empathy. In this sharing, Mutuality is experienced as a feeling of intimacy, connection, and understanding of another.

Other researchers describe associated characteristics possessed by nurses as:

- a) Empathy (to feel inside) and sympathy (to feel with).
- b) "A feeling of connection and understanding of another resulting in mutual problem-solving" (Grover, 2005, p. 179).

Antecedents (Demeanor/Disposition/Style)

A first-step in the nurse-client interaction process is the client's motivation to seek health care. "A state of readiness to act is by its nature invisible but becomes visible as the nurse-patient mutually agree and cooperate in sharing a goal or purpose" (Sahlsten et al., 2007, p. 633), even during a momentary encounter between them. Another antecedent is the nurse's desire to develop an interpersonal style that facilitates comfort with mutual involvement. Consequences include acquisition of individual situational control, empowerment, self-determination, self-efficacy, and improved problem-solving (Sahlsten et al., 2007) through presence and intention.

McCann and Baker (2001) also outline the strategies used by nurses concerning 'mutual relating' to be: (a) attempting to understand, (b) being friendly, (c) tuning in, (d) revealing

oneself, (e) being there for them, and (f) maintaining confidentiality. The idea that “a collaborative and consensual relationship is founded on respect and reciprocal understanding of each other’s role and responsibilities in that relationship; an alliance” (pp. 532-535) is stressed.

Neff, Brabeck, and Kearney (2006) describe this as ‘mutuality style’ in that nurses of this disposition try to “balance concerns with the self’s needs and feelings and concerns with the other’s needs and feelings” (p. 569). How nurses relate to patients, through presence and perceptive awareness of the other, promotes clarity between the health situation of the patient and the quality of contributions from nurses (Grover, 2005; McCann & Baker, 2001; Miller, 2008; Neff et al., 2006; Shim, Landerman, & Davis, 2011).

Explicit, is to possess an attitude of unconditional acceptance and respect of personhood, as outlined by Porr (2005). The autonomy of each participant is required, as well as a conscious experience of both participants in which egalitarianism is practiced (DeJesus, 2009; Zoffman & Kirkevold, 2005). The nurse’s concern becomes not only for the physical condition of the patient but also for incorporation of the meaning an illness has for the patient and significant others in these life experiences (Briant & Freshwater, 1998). The aforementioned authors go on to credit “a reverence for individuality and diversity of people and a true valuing of a person’s opinion, judgment, and contributions” (p. 211) as a pre-existing disposition for nurses who strive to achieve Mutuality in setting a therapeutic tone.

A priori is the nurse’s desire to develop an interpersonal style that facilitates comfort with mutual involvement (Henson, 1997) and Jeon (2004) suggests a lack of Mutuality is the first phase in the dynamic process of attaining Mutuality. Lastly, Geanellos (2005) asserts that Mutuality is not only triggered by ‘nurse friendliness’ but results in Mutuality.

Antithesis (Caveats)

Gadow (1980), the author of *Existential advocacy: Philosophical foundation of Nursing*, explains, "...the relationship between nurses and patients can slip over into paternalism and coercion when we are not careful" (pp. 84-85) (see Figure 2). Specifically, a risk for a non-traditional or strictly patriarchal, colonial, authoritarian stance, and prescriptive approach may develop (Cowling & Chinn, 2001; Watson & Foster, 2008).

Henson (1997) also explains that what appears to be paternalism "may actually be absolute autonomy" in some instances. The perception that patients may not be actually relinquishing decision making to paternalistic professionals, if they choose not to be involved is elucidated. "Rather, the autonomous client may be saying, 'Do as you please, I'm going to do what I want to do anyway'" (p. 78).

Briant and Freshwater (1998) claim a relationship of 'uneven power' between the nurse and client through the communicative process of transference is pervasive in nursing literature (p. 208). The authors emphasize it may be more appropriate to "think in terms of a relationship founded on the concept of mutuality rather than merely basing the nurse-patient relationship on equality or power-sharing" (p. 204). The notion of "relationships between individuals of unequal power can be founded on mutuality" (p. 210) is surmised. That is, the patient may look to the nurse as an authority figure and feel comfortable doing so.

Referent Terminology

Much of the social literature focuses on referent terms in the context of care givers (significant others) and their counterpart care recipients (patients) relationships. Also, authors oftentimes consider the following terms to be synonymous with Mutuality:

- Agreement
- Alliance

- Commonality
- Connection
- Consensual relating
- Intimacy
- Partnership

Association with Positive Health Outcomes

As discussed earlier, many researchers claim the benefits of Mutuality are advantageous to nurses and patients in the way of preserving human dignity and developing reciprocal trust, learning, a sense of belonging, personal role satisfaction, and an expectation of beneficial outcomes rather than a proclivity to authoritarianism (Curley, 1997; Vatne & Hoem, 2007).

In 2006, researchers from the Butler Center for Research with the Hazelden Betty Ford Foundation published a review of randomized clinical trials with a focus on patients with targeted disorders (e.g. mood, eating, & personality) treated with a wide range of therapeutic modalities. They concluded that development of a therapeutic relationship between a nurse and a patient is a consistent predictor of positive outcomes in therapy (Edwards et al., 2006), especially in decreasing anxiety during hospitalization.

Edwards et al. (2006), Kastle et al. (2010), LaRowe (2004), Quinlan (2006), and Varcarolis and Halter (2010), suggest Mutuality is a scientifically substantiated and evidence-based nursing intervention. Watson (2012) postulates a primary focus of nurses' communication when interacting with patients is to influence patients toward better health outcomes through the use of tangible nursing skills like assessment, health interview, active listening, etc.

Gaps in the Literature

This analysis is undertaken in order to identify gaps in the nursing literature concerning the concept of Mutuality and its use as a social competency in therapeutic relationships. Despite

the seminal works of Curley (1997) and Henson (1997) to study and describe the concept of Mutuality and its use in **nurse-client caregiver** relationships, knowledge remains limited as to its use in **nurse-patient** relationships. Overall, what appears to be lacking throughout the literature is a refined operational definition of Mutuality and how Mutuality is operationalized within nurse-patient relationships.

There is a dearth of research concerning Mutuality in nurse-patient interactions. However, it is evident that nurses have been incorporating the practice of Mutuality into nursing practice. At least five major gaps in the nursing and psychosocial literature were identified. These gaps include:

1. Extant evidence concerning the use of Mutuality in establishing therapeutic relationships. Rather, Hagerty and Patusky (2003) claim ‘small talk’ with a patient “becomes an important exchange during which nurses attempt to discover commonalities that facilitate connection” (p. 149), or achieving Mutuality. The notion that ‘small talk’ is a necessary component of effective communication in assessing a patient’s health status undermines the fact that oftentimes, patients may present in debilitated, obtunded, or speech-impaired states. Therefore, in these situations, patients are unable to engage in ‘small talk’.
2. A pervasive dyadic focus on Mutuality within caregiver-care and care recipient relationships, with caregivers typically being the care recipients’ significant other(s).
3. Testing and validating the assertion by Hagerty et al. (1993) that the intersecting point on the axial diagram of THR (see Fig. 3) is where Mutuality actually occurs between a nurse and a patient.

4. Distilled terminology related to Mutuality. Current terminology related to the concept is confusing (i.e. ‘partnership’, ‘alliance’, and ‘reciprocity’) (McCann & Baker, 2001). While these terms contain elements of the concept (e.g. definitions & components), there continues to be ambiguity in the meaning of the concept and its use in nursing. Hence, it makes it difficult for researchers to identify an operational definition and understandable use in nurse-patient relationships.
5. No existing psychometric tools designed to measure Mutuality in nurse-patient relationships. It follows that there is no supporting evidence that Mutuality is an effective nursing intervention used to promote patient safety and improve clinical outcomes.

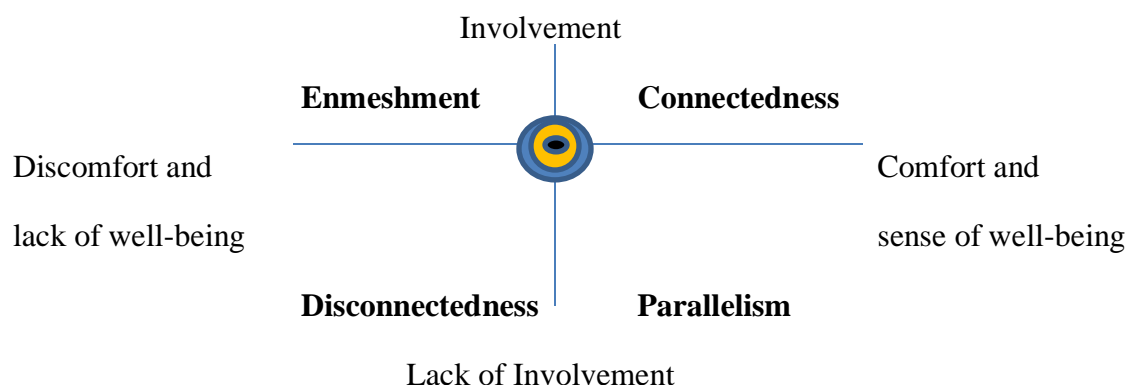


Figure 3. Point of Intersection on States of Relatedness Axiom

(Adapted from Hagerty et al., 1993)

Working Definition of Mutuality in Nursing

For the purpose of this literature review, the working definition used is that drafted by Hagerty et al. (1993), which is specific to THR. Namely, within the framework, mutuality is defined as “the experience of real or symbolic shared commonalities of visions, goals, sentiments, or characteristics, including shared acceptance of differences that validate the

person's world-view" (p. 294). Nelson (2000) postulates that an intersection of two processes of pure experience, the patient's and the nurse's, occurs when Mutuality happens (See Figure 1).

The likelihood that working definitions of Mutuality will change over time is also important. To date, real situations encountered in nursing characterizing the lived experience between a nurse and a patient, when Mutuality is used, have not been studied as it relates to connectedness.

Although the concept of Mutuality has been analyzed by researchers Curley and Henson in 1997, there is growing evidence that what was once believed to be 'mutual alliance' was termed an aspect of relatedness. However, the recent literature review elucidates a largely disciplinary adaptation to the use of Mutuality as a potential way to promote patient safety and improve clinical outcomes. Therefore, it is important to study the array of definitions and uses of the concept of Mutuality on an ongoing basis for comparison with newer data being collected on the nursing field.

Instrumentation

In 2008, Schumacher et al.'s description of the applied 15-item questionnaire named the *Mutuality Scale*, created by Dr. Patricia Archbold, Oregon Health Sciences University's, Academic Geriatric Nursing Capacity chair and Dr. Barbara Stewart is one extant account of studying the relationship between the client caregiver and the care receiver in family care. The researchers measured the concept of *mutual process* in the cancer population of a model of family caregiving.

Crist, Escandon, Stewart, and Archbold (2008) developed the *Mutuality of Autonomy Scale* instrument into a Spanish version and tested it by gathering evidence in their study entitled, *Cultural Equivalence of Mutuality in Mexican Americans*. Crist et al. (2008), note that in the psychiatric-related databases, this scale is used in Rorschach responses to test the relatedness

between objects, animals, and people in rapid-response fashion. These referents do not address the relationship between interpersonal communication and competency development of nurses.

Simultaneously, Tantillo and Sanftner (2010) developed the *Connectedness-Disconnectedness Scale (CDS)* used in psychometric testing to measure *perceived mutuality* in interpersonal relationships of women with eating disorders in a study conducted in 2008. This is another example of an instrument used to measure the presence of Mutuality in therapeutic relationships, but the context differs in that: (a) Mutuality is not measured within a nurse-patient relationship and (b) the aforementioned measurements are of the relationship between a patient and a disorder or ailment [physicality] and significant others, not a nurse. Future research will include exploring if the CDS can be adapted for future use in measuring Mutuality in the nurse-patient relationship specific to communicative processes.

Summary

In this chapter, literature was reviewed according to the theoretical framework of THR and the findings outlined through Rodgers and Knafl's (2000) Evolutionary Method of Concept Analysis. Foundations for the constructs of Mutuality, the bases for the definitions, descriptors, and the uses are discussed. The role and prevalence of Mutuality in caregiver and care recipient dyadic situations were analyzed.

Measurement issues are highlighted and the two more widely used and validated instruments to measure Mutuality in caregiver and care recipient dyads presented. Gaps in the nursing and psychosocial sciences databases concerning nurse-patient care dyads and measurement of Mutuality within those dyads were outlined.

Nurses are in a critical position to transform these alliances into therapeutic modalities particularly as they impact on patient health outcomes (Cowling & Chinn, 2001; Watson &

Foster, 2008). Aside from this, there is equally meager documentary evidence for the idea that when Mutuality is used in a nurse-patient relationship, positive health outcomes are manifested.

CHAPTER 3

INTRODUCTION

In order to select an appropriate method for this study, classical phenomenology theories were analyzed and compared (e.g. Husserl [founder], Heidegger, Merleau-Ponty, & Sartre). Each of the aforementioned contributors is briefly discussed.

Methodology

Husserl (1859-1938)

Husserl, the principal founder of phenomenology, focused on *inter-subjectivity* between human life-worlds and how we, as conscious beings, interact empathically with each other (Crotty, 1998) to derive a sense of meaning. A fundamental belief is that we experience the world through deliberate acts of consciousness of one being directed toward an object or referent (Lindlof, 1995; Morse & Field, 1995).

Heidegger (1889-1976)

Heidegger developed the study of hermeneutics, which is the interpretation and understanding of human nature derived from examination of writings involving the concept of 'being-ness' (Crotty, 1998; Lindlof, 1995). Heidegger coined '*being-ness*' as *Dasein*, the nature of our being, and how we are in relationship with self and others (Crotty, 1998). The meaning of our experiences is viewed through an ontological lens. This relational view of the person and how we are with each other includes transactions between individuals (Morse & Field, 1995). Although it is important to explore the meanings of nurses' experiences with patients, the study is not targeted to understanding a nurse's being-ness with patients. Rather, it is to study nurses' perceptions of the interactions themselves.

Merleau-Ponty (1908-1961)

Merleau-Ponty focused on the embodiment of humanness and ‘*being-in-the-world*’ (Crotty, 1998; Lindlof, 1995; Munhall, 1994). That is, how we experience being-in-the-world and that awareness. This particular perspective is centered on studying the history, knowledge, background, and lifeworld of participants. The aim is to interpret the experiences of each participant and not necessarily for meaning (Munhall, 2007; Streubert & Rinaldi-Carpenter, 2011). This orientation to the study was not selected because the focus is not a nurse’s lifeworld but on the meanings of a particular event occurring in a therapeutic relationship.

Sartre (1905-1980)

Sartre searched for understanding of the unseen by bringing that “thing” to awareness. The philosophy most notably framed by Sartre is *existentialism* (Crotty, 1998; Munhall, 1995). By definition, existentialism is the belief that philosophical thinking begins with human beings. As a result, we construct our belief systems from meanings we assign to objects and lived experiences (Sartre, 1957). While the Principal Investigator will attempt to make sense of the meanings of thoughts and ideas expressed by nurses, the focus of this study is not on constructionism. Therefore, this philosophical approach will not be used in this study.

Overview of the Study

The methodology and research procedures used in the study are presented in this chapter. The primary purpose of the study is to examine individual nurses’ perceptions of Mutuality within nurse-patient relationships in an acute care setting. This will give context to their everyday work-based lives and how perceptions of their interactions with patients are linked to this social competency. This is of particular interest in generating new nursing knowledge and identifying ways to promote patient safety and improve clinical outcomes.

The following sections are included in this chapter: (a) research question, (b) study design, (c) study procedures, and, (d) data management and analysis.

Research Question

The following research question will direct this study: What are nurses' perceptions of Mutuality and its use in their communication with patients?

Study Design: Introduction and Description

An exploratory, descriptive study using Husserl's (1859-1938) phenomenological inquiry (analyses of intentionality) is selected. It is considered to be the most favorable method to direct the exploration, analysis, and description of a particular behavioral (action) phenomenon (Streubert & Rinaldi-Carpenter, 2011) for the following reasons:

- 1) To explore a concept that appears to lack maturity in its development as a characteristic of therapeutic relationships between nurses and patients. In tandem with the inquiry process, using the THR model has the potential to serve as a unifying theory to explore the key aspects of Mutuality by obtaining a full array of data.
- 2) Discovering the essence and attributes of a concept is attained by studying the relationship between subject and object as conscious beings living a shared experience. Conscious beings often develop an awareness that, "I can do something about this or my situation" (Munhall, 1994, p. 149). In the context of nurse-patient interactions, the phenomenological inquiry approach and method of data analysis "can provide knowledge about aspects of the person's lived experience that cannot be accessed by observation alone" (Edward, Welch, & Chater, 2009, p. 589). Applying phenomenological inquiry to data analysis of participants' perceptions will allow the 'unknown' to reveal itself through intangible and tangible language.

- 3) Nurses are educated and skilled in engaging and involving patients with intention in order to glean accurate critical assessment data. Accurate critical assessment data, versus hearsay, is needed to craft and implement effective treatment plans and is accomplished through caring acts (Watson, 1999 & 2014). Studying perceptions or the ‘about-ness’ of the lived experience itself (Munhall, 1994) is important in the totality of those experiences when it does not yet make sense in everyday nursing practice.
- 4) Qualitative research is needed in health care services to provide “evidence on appropriateness (i.e. the extent to which care can be said to meet the self-perceived needs of the person to whom it is being offered) and evidence of the factors that affect decision-making among policy-makers, clinicians, and patients (i.e. why people, both lay and professional, behave as they do when they do)” (Popay, Rogers, & Williams, 1998, as cited by Munhall, 2007, p. 565).

Study Procedures

In this study, to achieve and maintain a naturalistic state, the Principal Investigator (PI) will strive to suspend any presuppositions, assumptions, preconceived ideas or notions of what might be shared by participants. Husserl describes this suspension of presuppositions as ‘bracketing’ (Munhall, 1994; Streubert & Rinaldi-Carpenter, 2011).

The following study procedures are used to achieve the goals of the topic of investigation. The setting, participants, and recruitment are described.

Setting

The acute care setting selected for this study is Maui Memorial Medical Center (MMMC) located in Wailuku, Hawai`i. A description of the facility and services offered follows:

- First established as Malulani in 1884 and subsequently renamed Maui Memorial Medical Center in 1963. It is currently a subsidiary of the Hawai`i Health Systems Corporation (HHSC) but will become an entity of Kaiser Permanente of Hawai`i on July 1, 2017.
- Located in Wailuku, Hawai`i on the island of Maui
- A 213-bed general medical and surgical acute care facility
- Adult procedures and management of conditions include, but are not limited to:
 - Chronic Obstructive Pulmonary Disease
 - Heart bypass surgery
 - Heart failure
 - Hip replacement
 - Knee replacement
- Adult specialties include, but are not limited to:
 - Gastroenterology and GI surgery
 - Oncology
 - Neurology and Neurosurgery

(<http://www.mauimemorialmedical.org/our-hospital>)

In a 2009, MMMC Scope of Service report, the RN Unit Managers of Maui North (MN) and Maui South (MS) describe the unit-specific staff mix and services offered as:

Purpose of the facility. The purpose is to provide nursing care for Adult Medical/Surgical patients.

Goals. The following are the facility goals:

- Provide accountability at the level of the caregiver, involving all nursing personnel in Performance Improvement activities.
- Maintain ongoing monitoring of the performance of nursing personnel.

- Integrate quality and management methods, practices, concepts, and beliefs into the structure of our organization to bring about continuous improvement.
- Facilitate collaborative work with medical staff, administration, other hospital departments, and external customers, to successfully improve the functions in which we are involved.
- Meet the legal and professional requirements and standards of hospital accreditation organizations.

Ages of patients given care. Generally, the clientele are adults.

Scope of current and planned services/practices. The MN and MS nursing units are acute medical/surgical settings with a total capacity of 43 beds combined (N=29 on MN; N=24 on MS).

Availability of Staff/Staffing. A profile (list of job classes) of staffing available to each unit, including contract staff, is as follows: Nurse Manager (1), RNs (N=27 on MN; N=22 on MS), LPNs (1), NAs (22), Health Unit Clerks (HUC) (3), and Transporter (1).

Staff RNs (full-time RNs) work three 12-hour shifts per week and one 8-hour shift every other week to equal 40 hours a week. The methods used when staffing needs to be increased to meet services include increasing hours for part-time RNs, overtime, float from another floor, float pool, and contract/agency RNs.

(Excerpted from Maui Memorial Medical Center's Policies and Procedures, Policy #512-100-01 entitled Scope of Service, effective as of January 2009)

Educational levels of RNs. In a personal interview with MMMC's Staffing and Resource Manager, the following are the reported levels of education of the RNs on each unit, respectively:

- N=6 with BSN; N=16 with ADN; N=0 with Diploma on MN

- N=6 with BSN; N=19 with ADN; N=2 with Diploma on MS

(Personal communication with C. A. Igarta, on November 20, 2015)

Methods used to assess and meet the patient needs/services. The factors used to determine staffing patterns are in need of adjustment to meet service demands. Improvements would include increasing hours for part-time RNs, overtime, float from another floor, float pool, and contract/agency RNs. Modified team nursing is provided. A total of 6 RNs are needed for day shift. One RN is assigned to be Charge Nurse and the other five are Team Leaders. Night shift is comprised of four to five RNs.

Recognized standards/guidelines used. Unit expectations with regard to workload and procedures within the unit are as follows:

Assignment of patient care will be done by the Charge Nurse. Assignments will reflect patient care needs, patient care goals, and the capability of the staff. Assignments followed the practices outlined in the nursing policy and procedure, infection control, safety, and job description manuals. The nurse responsible for making assignment was familiar with these policies and procedures and reviewed them as necessary to keep information current.

(Excerpted from Maui Memorial Medical Center's Policies and Procedures, Policy #512-100-01 entitled Scope of Service, effective as of January 2009)

Participants

For the progression of this study, the target population was staff RNs. Of the two counterparts in a nurse-patient dyad, the PI selected the RN counterpart to interview first as nurses are charged with establishing therapeutic relationships by engaging patients while bearing the responsibility of fulfilling a helper role (see Chapter 1). Therefore, patient counterparts will be interviewed in a subsequent study concerning their perceptions of Mutuality.

Recruitment

Participants were drawn from the MN and MS nursing units. A survey of RN participant demographics included age, gender, ethnicity, length of practice experience, and educational preparation (See Appendix B). This data was analyzed post-study in order to statistically report participant characteristics.

The PI scheduled a meeting with the RN Unit Managers for MN and MS. Following consultation with the managers, the PI coordinated informational meetings with unit-assigned staff RNs and discussed the purpose of the study, progression of the study, study procedures, participant Consent form (see Appendix A), and RN Data Sheet (see Appendix B). The PI sought participation from those RNs who had attended the informational meetings.

Inclusion/Exclusion Criteria

According to established protocol for this study, eligible participants were described as:

- 21 years of age or older
- Any gender
- Reliable and competent in answering interview questions within a 1-3 week period of time
- Current practice (part-time or full-time) of at least 3 years in some form of medical-surgical nursing
- Graduates of diploma-awarding, associate degree, baccalaureate degree, and/or post-graduate RN program(s)

These delineates were selected to assure a length of time in which a variety of therapeutic relationships would have occurred, apart from the specialized bonds which may be the norm (Ramos, 1992) in critical care, intensive care, or infant and maternal care units, for example.

The PI is employed with the University of Hawai'i (UH) system as a nurse educator. She conducts clinical activities at MMMC with nursing students enrolled in the UH Maui College (UHMC) Nursing Program. The PI is not employed by HHSC or MMMC. The existing relationship with the facility, patients, RNs, and ancillary staff is as a supportive faculty member to the nursing students under her tutelage. The interviews were conducted on days other than assigned clinical practice days with UHMC.

Sample size

A purposive sample of 6-8 RNs was recruited for the purpose of data collection and analysis.

Interview protocol

An in-depth interview process was used to gather contextual rich descriptions to reveal what is 'unseen' through a nurse's reflection of recent incidences. Munhall (2007) explains that the purpose of the interview is "to gather information about the life-world or everyday experience of the interviewee and that the researcher has the task of seeking and interpreting the meaning of these everyday experiences" (p. 410). Therefore, the participants were allowed to respond freely (see Table 1).

Interviews were conducted at times that were convenient for the participant interviewees. Immediacy of interviewing was helpful so that recent exchanges with patients are "fresh" and therefore, details more readily recalled by the participant. The PI and the volunteering RN participant met in-person outside of the facility and on the UHMC campus. The Consent Form (see Appendix A) and RN Data Sheet (see Appendix B) were reviewed and completed.

No interview questions were shared with any RNs in advance of the interviews. Each interview session began with the same questions, read verbatim (see Table 1). A 30 to 45-minute

audio-recorded interview session was conducted with each participant in a secured and private room located on the UHMC campus.

Table 1. Guideline of Probes: Statements and Clarification Questions

Probes	Statements and Clarification Questions
"Tell me a story about a time you felt you and the patient had connected."	"What do you think is going on when you connect with a patient?"
"Tell me about the most powerful time you and a patient had connected and the outcomes were good. Was there a change in the plan of care after the connection?"	"If so, please describe."
"Can you describe a time when connection was not there or when you felt you had connected but the outcomes were adverse?"	"If so, please describe."

The above-listed interview questions were designed to be open-ended, in an effort to elicit free-flowing and broad narrative responses from the participant. This was important in order to “avoid forcing clarity or specificity from an interviewee who is ambivalent or ambiguous about the life situation” (Munhall, 2007, p. 410). Impromptu probing questions were unknown at the time of the interview as they were used to clarify the meaning of language (tangible and intangible) expressed by the RN participant in the course of the interview.

It was decided that should interruptions occur when an interview was in-progress, the PI would make arrangements with the participant to complete the interview at a later date and time. When necessary, follow-up questions were used to gain additional information, insights, or clarification of meaning.

Data collection

In an effort to mitigate the PI inserting biases during the interviews, the following bracketing strategies were used:

1. To focus on participant expressions in order to discover the feelings, habits, and meanings underpinning the nurse’s intention to establish a therapeutic relationship with the client and the client’s intention to seek care provided by a nurse. This was helpful in providing a holistic picture of what ‘real life’ in everyday practice of RN participants.
2. To consider inter-subjectivity to be a factor in how the PI conducts the interviews with participants. Therefore, the PI employed the research strategy of ‘bracketing’ in an effort to avoid PI bias. That is, the PI worked to abandon any assumptions or pre-conceived notions of the nurse-patient encounter and instead, adopted and maintained a stance of ‘unknowing’ (Munhall, 2007). This was important so that the PI remains

mindful of boundaries that may exist between the PI and the participant which might have prohibited open sharing of participant ideas, thoughts, and feelings.

3. To apply an iterative process in this manner, the PI decided to conduct follow-up interviews if needed, to closely examine RN participants' perception of the topic being investigated.

Timeline

The projected timetable for completion of the study is described in Table 2 below.

Table 2. Timeline

Task	Projected Time Amount (Weeks)	Beginning Date (2017)	Projected Deadline (2017)
IRB application submission	3-4 weeks	April 10	April 28
Participant interview	1 week	May 10	May 18
Coding & transcription	1-3 weeks	May 10	May 31
Member-Check	4-7 weeks	May 22	July 15
Data Analysis	8-13 weeks	May 15	August 21
Write chapters 4 & 5	13-15 weeks	May 5	September 3
Dissertation Defense			October 25
Completion of degree			December 14

Data Management and Analysis

As a novice researcher, the PI had conducted a critical reading of available data analysis approaches (Colaizzi, Giorgi, Paterson & Zderad, van Kaam, van Manen, & Streubert) and decided the most appropriate method to use for this step of the research was Colaizzi's (1978) Nine-Step Process of Comparative Data Analysis. The PI deemed this method most appropriate as it is structured and will allow the PI to attend to terminology and themes that are specific to 'intersubjective mutuality', power structures, and processes that can "impede equal, free, and uncoerced participation" (Munhall, 2007, p. 132).

Colaizzi's (1978) method includes the following:

1. Describe the phenomenon of interest.
2. Collect participants' descriptions of the phenomenon.
3. Read all participants' descriptions of the phenomenon. All oral or written descriptions are read in order to obtain a feel for the whole. Significant statements and phrases pertaining directly to the phenomenon are extracted. Significant statements are summarized and restated using participants' language. Meanings are formulated from these significant statements and phrases. Meanings are clustered into themes (Kim, 2014; Munhall, 1994).
4. Return to the original transcripts and extract significant statements.
5. Try to spell out the meaning of each significant statement.
6. Organize the aggregate formalized meanings into clusters of themes.
7. Write an exhaustive description.
8. Return the original transcripts to the participants for validation of the description (member-check technique).

9. If new data area revealed during the validation, incorporate them into the exhaustive description. Any additional new data is incorporated into the fundamental structure of the experience” (Kim, 2014; Munhall, 1994; Streubert & Rinaldi-Carpenter, 2011).

The PI’s objectives of the study fit with Colaizzi’s (1978) method of data analysis as outlined by Munhall (1994). Informing the concept of Mutuality required identifying the events and interactions that represent key aspects of Mutuality. Additionally, the essence of Mutuality, the characteristics, traits, and values of the participants, and timing-related concerns (e.g. nature of the environment when interviewed, pace of the interview, time allowance for member-check of data & follow-up clarification(s) with participants) were studied.

Categories of descriptions yielding the dimensions of variation using collective analysis of individual descriptions (Munhall, 1994) were framed. The data was analyzed as a collective with the aim of identifying possible conceptions of experience related to the phenomenon under investigation (e.g. meanings & significance of conceptions). Meanings were studied so as not to restrict the phenomenon to a definition, category, or construct (Streubert & Rinaldi-Carpenter, 2011). This critical analysis was important in not only hearing the language and the PI “believing something has been revealed” by the counterpart, “but hearing and also contemplating what might be concealed in the responses” (Munhall, 2007, p. 149).

Following the transcription of the audio-recorded interview, member-check was conducted with the participant to ensure accuracy of the thoughts conveyed during the interview. The transcripts were delivered either electronically or via hard copy to for further review and editing. After member-check, the data was analyzed by studying meaning units as expressed verbally, non-verbally, and inferentially by each participant.

Data from the interviews and stories was grouped into meaningful clusters (units), explicated, and analyzed using thematic content analysis. Data saturation included observed body language when participants verbalized their personal experiences, as well as feelings, insights, interpretations, and core values expressed. That is, saturation was met through “obtaining a full range of themes from the participants, so that in interviewing additional participants, no new data are emerging” (LoBiondo-Wood & Haber, 2010). This was important so that the meanings of the perceptions would be illuminated and the key aspects of Mutuality revealed.

It was anticipated that given the large volume of verbal data collected, data saturation would be reached within the aforementioned sample size. Detailed analysis of a large volume of verbal data, as well as intensive contact with participants was expected. The personal stories were analyzed for descriptions, patterns, and relationships between themes and meaning units as articulated and intimated by each participant.

Demographic characteristics of the participants were outlined for the purpose of describing the composition of the target population and identifying key themes and meaning units. Field notes concerning non-verbal behaviors were documented used in conjunction with the transcripts for interpretation of meanings.

Operational definitions and variables

Watson (1999) urges nurses to move “farther away from the reactive worldview, past the reciprocal and into the ‘transformative-simultaneous’ and to create nursing’s own post-modern paradigm” (as cited by Munhall, 2007, p. 44). In order to study and systematize the observations and descriptions of the concept of Mutuality, the PI observed, discovered, and used commonsense thinking to engage in logical deduction and induction, search for meaning, develop insights, test out ways to organize data, and speculate about the types of relationships

between meaning units and themes expressed by study participants (Rodgers & Knafl, 2000). Norris (1982) stated that “an operational definition answers at least one question: ‘How will I know the concept when (in the broadest sense) I see it in operation?’” (as cited by Rodgers & Knafl, 2000, p. 198). To address that question, the PI contemplated the following:

It is uncertain that any observable indicators of Mutuality, or *mutual avoidance*, exist in therapeutic relationships between nurses and patients as the perceptions are subjective. As a result, Mutuality was operationally defined by tangible (verbal) and intangible (non-verbal & inferential) communication of each nurse participant. Tangible and intangible communications include verbal statements and sensations, feelings, or animations respectively.

Verbal statements and sensations shared by subjects were expected to include the following and are presented in dualistic fashion concerning individual perceptions of:

- A “connection” or “disconnection” with a patient (e.g. “the patient was indifferent to me”)
- Openness or “scared” or reluctant/hesitant to share her/his thoughts or needs
- “Present”, a sense of “being there”, or “distant” from the patient (perhaps felt rushed, pressed for time, or hurried)
- Feeling “heard” or “dismissed”
- Certainty that “the patient knew I was there for her/him” or “didn’t seem to see me”
- The patient “really wants to know what I think” or “doesn’t care to know what I think” or “has already made up her/his mind (i.e. a fixed viewpoint)”
- The patient “understands me” or “gets it” or “doesn’t have a clue”
- Non-verbal language exhibited during the interview might include the following and are presented in dualism fashion:

- Smiling or frowning
- Giggling, laughing, or wearily sighing or eye-rolling
- Gesturing (head, hands, or body movements)
- Maintaining an open or closed posture

Software

The NVivo Pro 11 TM software, which is a highly structured code system, was utilized for data analysis as it was helpful in making links between text and hyper-text. That is, source tags attached to the datum allow the capability to alert the PI to where the information was coming from (e.g. the specific participant) (<http://www.qsrinternational.com/product>).

Protection of Human Subjects

The Basic Ethical Principles Relevant to the Conduct of Research as enacted by the U.S. Department of Health, Education, and Welfare (1973) were employed. The principles include: 1) Respect for Persons; 2) Beneficence; and, 4) Justice. To protect each study participant's right to self-determination, each was informed of her/his right to participate or not participate in the study.

To promote beneficence, the PI assumed the obligation to do no harm and to maximize the possible benefits to participants. To promote non-maleficence, participants were treated in an ethical manner, their decisions respected, and efforts made to secure their well-being (e.g. HIPAA guidelines in the gathering & storage of private information). Lastly, to promote justice, participants were treated fairly by being asked the identical set of probing questions, at a time and place that was convenient and private for the participant, and for the duration of time that was not perceived as burdensome for the participant.

To follow guidelines as established by Collaborative Institutional Training Initiative (CITI): Explanation of the study, including potential harm through use of the Consent Form (see

Appendix A), assertion of facility's corporate HIPAA policy, and codification of data was used to protect participant rights of participation or non-participation in this study.

Maintaining confidentiality of participants was an important issue for this study. Because of the sensitive nature of the patient care experience and participants' sharing of emotions, confidentiality of thoughts and feelings shared was maintained in an effort to not only guard participant privacy but to maximize honesty in self-reporting.

Each interview transcript and RN Data Sheet (see Appendix B) was coded by alpha and number (e.g. RN1, RNII, RNIII) so that no name of a participant or other identifying data was utilized for the purpose of data analysis. The coding process was checked by a veteran qualitative researcher to ensure participant privacy. Transcripts were placed in a locked location and will be destroyed after publication of the research findings.

Risk factors, as identified in the Consent Form (see Appendix A), related to the possibility of emotional discomfort that might result from the emotions triggered from the question content. All participants were encouraged to discuss any discomfort experienced with private practice clinician or the licensed social worker at MMMC. Informed consent procedures were in accordance with the guidelines of the University of Hawai'i Human Subjects Review Board and CITI at the University of Miami's Human Subjects Research organization protocols.

Limitations

The PI assumed a stance of wanting to understand the RNs' perceptions of Mutuality. To grasp that reality, different perspectives resulted in different interpretations of the phenomena. Using this stance, the PI interpreted meanings, as expressed by each RN participant, and anticipated that those meanings were beyond the findings concerning Mutuality as presented in Chapter 2 (see Literature Review section).

Potential limitations in conducting the study included, but were not be limited to:

1. The potential for the PI not strictly adhering to ‘bracketing’ procedure during interview process, given her 23 years of medical-surgical nursing practice experience may influence her interactions with colleagues.
2. Only one counterpart of the care dyad was interviewed in this study. However, the concept of Mutuality in its totality is assumed to occur between counterparts (e.g. at an intersecting point on an axiom). Given the subjective nature of nurses’ experiences and the possible assumptions made, the patients (the counterpart in the relationship) were not interviewed. Additional associated biases included points of view of the nurse’s communication style/ability/proficiency, or lack of, or interpretation of/lack of, that possibly impacted the findings of the study.
3. RN participants may not readily identify or report significant interactions so that timely interviews can take place.
4. The participant might be unwilling to be audio-recorded.
5. Any extensive time lapse (e.g. greater than three 12-hour shifts) between when the RN perceived an interaction concerning the topic being investigated and reported it to the PI could affect the RNs’ recollection of event details.

Summary

Analysis of collected data from nurses’ everyday work-based lives generated new nursing knowledge concerning ways to improve communication with patients, patient safety, and positive clinical outcomes. These ways to improve communication, patient safety, and positive clinical outcomes are discussed in the next chapter.

CHAPTER 4

INTRODUCTION

The purpose of this descriptive study was to explore the social competency, Mutuality, within a nurse-patient relationship. The model used was social competencies of the Theory of Human Relatedness (THR) typology developed by Hagerty et al. (1993) and expands to include key aspects of the concept of Mutuality. An understanding of the nature of relatedness underpins the framework with the idea that “nurses could intervene more quickly and appropriately with clients rather than relying only on traditional approaches” (p. 294) of how to establish nurse-patient relationships via *States of Relatedness*.

Results

Overview of Data Analysis

Presented in this chapter are the analyses of the data collected from six respondents in this study. For the purpose of this study, the constituent elements of the concept of Mutuality (evolution, aspects, terminology, & assumed associations to health outcomes) were explored.

The NVivo Pro 11™ software, which is a highly structured code system, was utilized for data analysis and was helpful in making links between text and hyper-text. That is, source tags attached to the datum allow the capability to alert the PI to where the information originated (e.g. the specific participant). Emerging themes were “uncovered” and mapped.

What arose from the data analysis were not only anticipated stories concerning the plausibility in the working use of the key aspects of Mutuality, but also unanticipated phenomena. The anticipated data informed and actualized the concept of Mutuality and is described below.

Objectives and Assumptions

The primary objective of this study was to explore the social competency of the Theory of Human Relatedness (THR) model, Mutuality. Because there is no existing instrument, an exploratory and descriptive data collection strategy (interview) was used. The data was analyzed for anticipated (planned) results as well as unanticipated (phenomenological) results and is discussed.

Procedural objectivity by the PI in order to keep the relativism outside of the PI was maintained. This included *neutrality* in order to suspend judgments about the “goodness” or “badness” of the data and to enhance rigor, consistency, and thoroughness. *Descriptive realism* to produce in-depth, narrative accounts of everyday work life, lived up close by practicing staff RNs was assumed. The type of interview was natural (informal & spontaneous) with the role of the interviewer being moderately nondirective, unstructured, and in accordance with exploratory phenomenology.

The demographic characteristics of the sample are summarized and inform the concept of Mutuality. Through the process of analysis, the data was the organization into data sets and labeled as Categories (including frequency of occurrences), Theme Clusters, and Themes in accordance with Colaizzi’s (1978) Nine-Step Process in Comparative Data Analysis method (see Appendix C).

Summary of Sample Demographic Characteristics

The RN Data Sheet (see Appendix B) was used to collect the demographic characteristics of the six RN participants. A total of twelve RNs were recruited. The recruits consisted of nine females and three males who had never been in direct line service with the PI during employment.

Of the twelve recruits, only six female recruits agreed to participate and be audio-

recorded. The mean age of the respondents was 48.2 years with an age range between 38 to 53 years. The sample was predominantly Asian (N=4; 77%) and Asian/Pacific Islander (N=2; 25%). This number is an aggregate of Asian, Hawaiian, and Caucasian.

These demographics do not appear to be representative of the nursing workforce in Hawai`i as outlined in the Hawai`i Center for Nursing's 2017 Nursing Workforce:

- 1) 13% Male
- 2) Top five ethnicities:
 - a. Caucasian 31%
 - b. Filipino 31%
 - c. 2 or More 13%
 - d. Japanese 11%
 - e. Native Hawaiian 5%
 - f. Other 9%
- 3) 54% of working RNs are 45 years old and younger
(<http://www.hawaiiicenterfornursing.org/data-reports/>)

While the composition of the nursing workforce was not the focus of this study, the discrepancies between the demographics as reported by the Hawai`i State Center for Nursing and the atypical profile of the target group for this study are further discussed in the Limitations section (see Chapter 5).

All participants were employed full-time and serving on a medical-surgical unit located on the fourth floor of MMMC. The primary language spoken was English. Of the six participants, five had formerly graduated from an Associate degree nursing program and one had earned a baccalaureate degree in nursing. Lastly, the mean number of years of employment was 17.8 years with the career years of employment range was between 10 to 30 years.

All were interviewed within 24 hours of their previous 12-hour shift so that individual recall would be immediate and enhanced.

Ethical Considerations

The study received institution ethics approval from the University of Hawai`i's Human Subjects Studies Program (IRB Protocol No. 2017-00245). Registered nurses who intended to

participate in the study were given a brief explanation at the time of the interview. Participants signed the Consent Form (see Appendix A) and were given a copy. Included in the Consent Form was agreement to be audio-recorded. Participants were told there was no remuneration for their participation and they had the right to end the interview at any point or withdraw from participation in the study at any time.

Research Question and Planned Methodology

The research question that directed this study was: “What are nurses’ perceptions of Mutuality and its use in their communication with patients?” The data sets consisted of interviews with RNs to elicit their perspectives concerning connecting with patients in a therapeutic way. The thematic framework was exploratory and data saturation was reached after six interviews. Planned methodology included studying Mutuality as operationally defined by expressions of tangible and intangible communication of each nurse participant.

Description of Responses

Tangible communication included verbalizations and intangible communications included non-verbal behaviors and inferences, as well as observations of sensations, feelings, or animations exhibited. The data was organized into Verbal, Non-Verbal, and Inferential communication sections. Notable is that the RNs thoughts and ideas were congruent with theoretical aspects of Mutuality. Additionally, antithetical responses are notable and discussed.

Verbal Communication

The data was initially analyzed for a priori character traits arising from the respondents and are categorized below as formerly discussed in Chapter 2:

- Attributes (see p. 32)
- Antecedents (see p. 33)
- Antithesis (Caveats) (see p. 35)
- Referent Terminology (see p. 35)

- Association with Positive Health Outcomes (see p. 36)

The diagram below (see Fig. 4) displays the above categories with the number of occurrences extrapolated into percentages from the interviews in total.

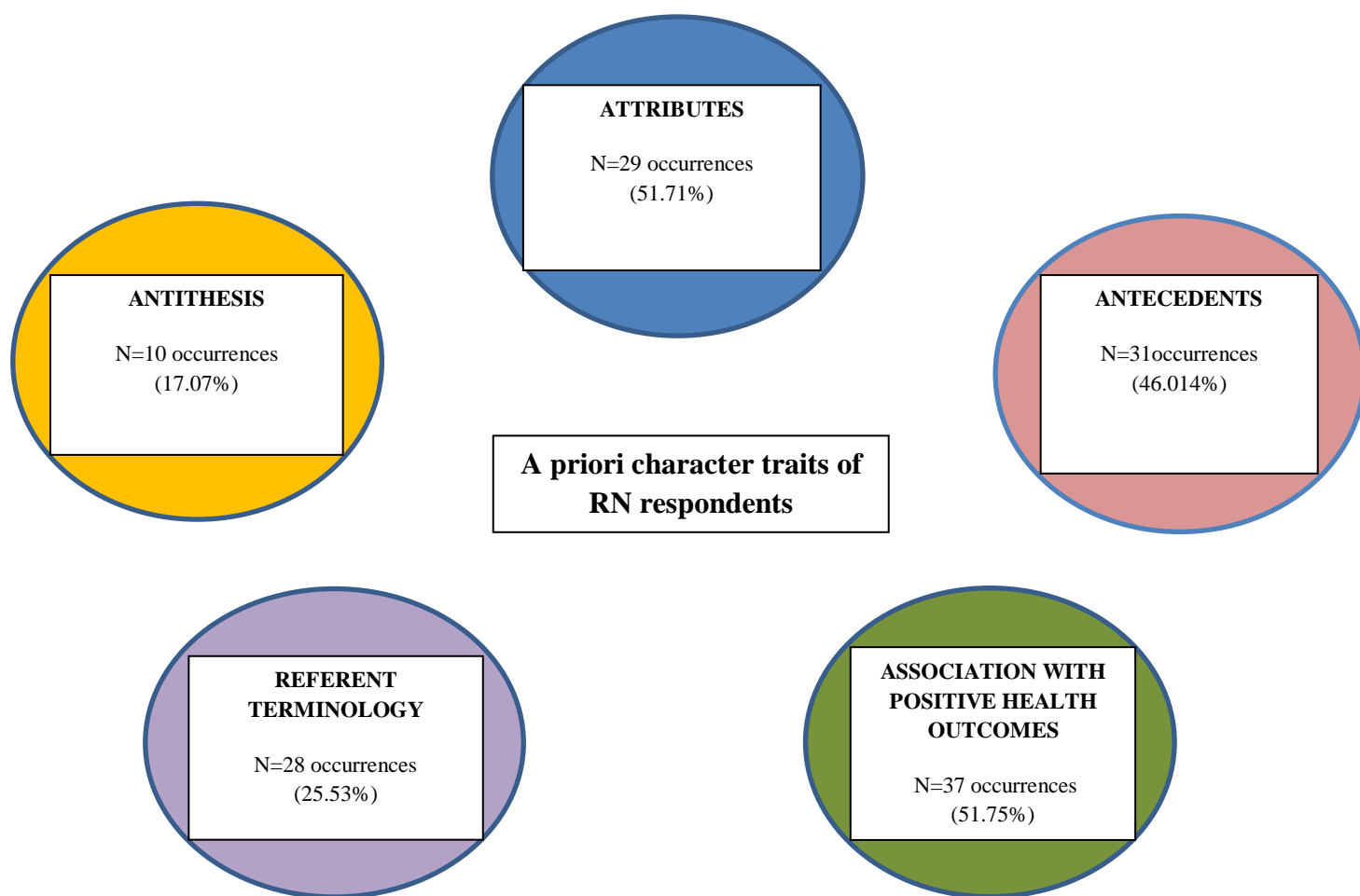


Figure 4. Data Analysis: A priori character traits of RN Respondents

Each respondent was asked the probe questions followed by clarification questions when required (see Table 1). Since the analysis process is specific to Colaizzi's method, six categories were identified (including frequency of occurrence statistics). Then, six theme clusters (key aspects of Mutuality – see Chapter 2) are listed. Finally, nineteen themes (see Table 3) are

synopsized. Beneath the table, a brief description of each theme cluster (aspect of Mutuality) is reiterated, as well as any RN inferences and/or statements made in the transcripts.

Table 3. Categories (including frequency of occurrence), Theme Clusters, and Themes using Colaizzi's method

Categories	Theme Clusters	Themes
(Arranged according to frequency of occurrence of inferences or statements made) 1. Ameliorating stress and anxiety; enhancing comfort N=38 (51.71%)	(Arranged according to each key aspects of Mutuality) <i>Therapeutic Use of Self</i>	Putting the patient at ease; patient becomes visibly relaxed or states an increased comfort level post-discussion with RN; improved quality of sleep; progressive adherence to a prescribed therapeutic management plan
2. A sense of togetherness or working together* N=38 (51.71%)	<i>Intentionality</i>	Initiating patient responsiveness; shared goal-setting for healing, comfort, and basic needs; camaraderie; deliberateness in calming and reassuring the patient; encouraging openness concerning health needs
3. Joy in discovery* , privileged access, and satisfaction in self-efficacy N=35 (51.71%)	<i>Authentic Caring</i>	Provision of care of patient seen as an opportunity by the RN; inferred as a privilege; "I get to" ... "doing my job better"; personal satisfaction in being effective in the provision of nursing care and resultant positive health outcomes

Categories	Theme Clusters	Themes
4. Acknowledging patient individuality/ personhood N=28 (43.25%)	<i>Use of Essential Personhood</i>	Protecting patient privacy (primarily in relation to family members)
5. Connection N=28 (25.53%)	<i>Connectedness</i>	Essential; All participants emphasized the importance of connection and connectedness with in-patients
6. Fostering independence; energy exchanged* N=7 (17.07%)	<i>Equity and Reciprocity</i>	Establishing trust; rapport; shared language; finding an opening in communication/ conversation and “jumping on it!” (re: opportunity to assert options for the patient to choose between and among)

*Higher order of phenomenological patterns (see Unanticipated Data section)

Therapeutic Use of Self (N=38 inferences or statements made [51.71%])

“...he's not the educated one. He didn't go to school. He don't know what -- he's not the one to make that decision because his mind is so weak right now. So we need to pick him up and show him the right way and do it. But it takes energy and it takes time and it makes-- they pull off your energy. But if you tell them, 'Let's do it together,' I think they're less afraid, they're less-- their anxiety goes down and then you can get them up together because it's not a, 'Sure. Okay. You will get up out of bed! You need to get out of bed! [command]'. But it's, 'Let's do it together.'” (RNIV)

Therapeutic use of self is described as a dynamic developmental process within which shared feelings of intimacy, connection, respect of personhood, and understanding of another are key attributes. Through therapeutic use of self, nurses intentionally use their own personalities to establish relatedness, make nursing assessments, and structure interventions (Watson, 2012).

It is characteristic of nursing assessment that the very first connection between a nurse and a patient is meant to establish an understanding that the nurse is safe, a confidante, reliable, consistent, and that the relationship will be conducted within appropriate and clear boundaries (Travelbee, 1971). Another consideration pertaining to the use of self is that interdependence and influence in the relationships with others and a view of self becomes transformative (Hedelin & Jonsson, 2003).

Another characteristic of the aspect of therapeutic use of self is therapeutic communication. Hood (2010) states “when the nurse is deliberate and purposeful in establishing a level of communication with a client which promotes client openness (i.e. disclosing information, needs, & expectations) the client’s health needs are more likely to be met” (p. 471). Implicit is that Mutuality in communication must exist between nurse-client and may serve as a catalyst to ease client openness. In turn, it may promote reflection practices, gaining insight, and consciousness-raising of nurses concerning patients’ health needs.

Finally, it is thought that how skilled nurses foster free-flowing verbal and non-verbal exchanges with patients makes a difference in establishing a helpful relationship, rather than formal, forced, or mechanical exchanges (Watson & Foster, 2008; Watson & Smith, 2001).

Most of the respondents reported using their own style to extend themselves to patients.

Below are quotations from the transcripts in support of these findings:

“I think I respect their privacy. I mean, if they tell me things that they don't want me to say. I'm not talking about, "Oh, I wanna commit suicide." I'm talking about if they say they did drugs before. You know what I mean? I won't hold that against them. You know, if, if they drink alcohol or-- not try to judge them for that. You know what I mean? I think most nurses do. But I try to just establish a trusting relationship with them and it depends on the person. There's no single tactic that I can think of that I use. I mean, I just-- it's all-- the people are different they require different needs. Some people want to be doted on and some people just want to be left alone and I respect that. So, like, if I have a 93-year old who has a sodium level of 126 and she's on fluid restrictions, I'm not gonna lie; if she's thirsty I'm gonna give her water. I mean, she's-- you know what I mean? I, I do those little things too-- not to hurt them-- I'm gonna make sure that they don't have something metabolically wrong of course. But, I mean, I try to make sure that I can do little things like that to make them feel like they might be special in a way, so that they can, I guess, be more comfortable with me. Then I can do my job better.” (RNI)

“...but when I speak in his primary language, which is Ilocano, there is more of a connection...I was able to get a better idea that he was able to connect with me and communicate because now I'm speaking in his language. He was smiling throughout the day. I was able to pretty much provide better care and able to communicate...every time we told him not to do “that” in his language he would listen.” (RNIII)

"I'll work with you.” (RNIII)

“He goes, ‘Look, I think I did well eating my meal, don't you think?’ And I looked down I was like, ‘Wow!’ It was a lot. It was half of everything which that was the most that I had seen him eat even since last week. I said, ‘Yes, you did. You ate a lot.’ So I said, ‘We probably don't even need the tube feeding. So that's fine.’ I said, ‘It's up to you if you want it, great. If not, you don't have to.’ So I think he was really comfortable with everything. To me, I felt that was the most powerful thing; to see that patient improve within a week of time. I mean, it would be nicer if it was sooner than that but to see him finally get there, I think was most important.” (RNIII)

Intentionality (N=38 inferences or statements made [51.71%])

“I think on the night shift when the family is away and you have more time to be more of a friend, I guess...I don't know that ‘friend’ is a word to use instead of a nurse. You don't

have all the responsibilities you have during the day. It's just a quieter time...I know a lot of times the patients...they're not afraid to speak for themselves. 'Cause during the day they're kinda -- the family is guiding what they're gonna say. You know, they wanna adhere to what the family wishes are and they don't really tell you what they want.” (RNI)

According to Smith (2011), manifesting intention is defined as creating, holding, and expressing thoughts, images, feelings, beliefs, desires, and will in action. These actions affirm possibilities for promoting health and well-being. Deliberateness reflects consciousness, “a meaningful energetic blueprint for transformation” (as cited by Cowling, Smith, & Watson, 2008, p. E46). This approach is important for gaining knowledge concerning development of nurse ‘being-ness’.

All of the respondents emphasized their aim to be deliberate, not only in establishing rapport with patients, but also in being helpful. Evident in the statements are displays of compassion, candor, and the use of metaphors to convey understanding to patients. These are some statements from the transcripts:

“--I can't really distinguish that actual moment, but I think I may have been the one to initiate it. Not about-- not bringing her belief or religion into it. I just-- I think I'm the one who brought up...like, how can I—‘Tell me how I can help you’. Like, how can I—‘What can I do for you?’ I think it was more on that level.” (RNI)

"Yes. I guess she got scared that-- all the high risks that I kind of explained to her. She's young, and she has kids, like me, who need her-- so the husband and her decided, "Okay. I think you're right." But again, I said, "That's your decision. It's not me. This is just my suggestion as a nurse, but there's a process you can do..." (RNI)

“I think that was just an opportunity for her to talk about it and I jumped on it. You know what I mean? It was in the middle of the night. There wasn't really anything I could do but there was something I could do...” (RNI)

“...explaining most of their plan of care whether they like it or not.” (RNII)

“...if they're not sure what's happening to them, then I'll just sit down and ask, ‘What are your thoughts? Why are you concerned about the procedure?’” (RNII)

“I go in there and I ask him his name in that language. And right away, he perked up and he said his name.” (RNIII)

"I had to constantly just kind of educate him and let him say, 'Well, we need to try it just to see if this intervention would work or not'." (RNIII)

"I told him, I was like, 'Your heart has been racing 140 to 150 this whole week, like you're running a marathon. You know, you've been running this whole day or this whole week.'" (RNIII)

"I was like, 'Anything is better than nothing'." (RNIV)

"And I told him, 'I'm not lying to you. It's gonna be sore, it's gonna hurt. But it's gonna be even more sore if you don't get out of bed.'" (RNIV)

"...he's not the educated one. He didn't go to school. He don't know what-- he's not the one to make that decision because his mind is so weak right now. So we need to pick him up and show him the right way and do it." (RNIV)

"And we dragged her out of the bed. She was crying...out of bed and she walked down the hallway and she came back; we got her back into bed. And the two ladies were roommates. But that one lady who cried down the hallway, she went home three days earlier...and then the other lady who we didn't invest as much time and energy, she ended up getting the complications. She had a little bit of atelectasis, pneumonia, and then they get a little bit fever and it's just one thing after the other...So I definitely saw how early mobilization can push them forward and get them home. And that's what nursing is all about. It's not to have to succumb to their wants because they're not the educated one. They didn't go to school, they didn't take the anatomy, they don't know how the bowels work, but then you need -- even though they're scared, you need to grab them. Even though like pushing them." (RNIV)

"I just told her -- the way I told her, I said, 'If you were my mother, I think I would make an exception and have you here, versus, you know, what my beliefs were.'" (RNIV)

"...as to whether the family ever found out about it I don't know. But we put her in another room and the family came in in the morning looking for her-- I was the one who said she was in a procedure." (RNVI)

"...for someone who's already having pain, for you to just go ahead and just shove all this fluid in there -- you really have to meet that individual's needs. It's different than everybody else." (RNVI)

Authentic Caring (N=35 inferences or statements made [51.71%])

"I love it when I am able to see a change in a patient and see that they are feeling so much better knowing that they're fighting cancer and all...you hear them saying that they're in pain, they're in pain, and just yesterday he was saying he has zero pain or maybe like one out of 10 pain level." (RNIII)

Authentic caregiving is transformative and is built and sustained by nursing actions that develop Mutuality (Simone et al., 2014; Watson, 1999). One example is appropriate emotional vulnerability with patients. McCann and Baker (2001) surmise that such vulnerability entails building interpersonal relationships, which require an affinity for people, positive regard, wanting to get to know individuals, and the ability to engage freely in informal conversation.

This trait of relational being-ness holds Mutuality within the nurse-patient relationship as central to authentic caring (Falk-Rafael, 2006). Specifically, manifesting intention is critical since presence, resonance, sensitivity, and mindfulness progress into an evolving pattern of a nurse and patient therapeutic process. This aspect of relational being-ness holds Mutuality within the nurse-patient relationship as central to authentic caring (Falk-Rafael, 2006).

Respondents mentioned they consider continuity of care, safety, and the individual uniqueness of patients in their workday lived experiences, as indicated by the following statements:

“...set it at 100 (mL) an hour to go in really slow for him and I said, ‘As soon as you feel that discomfort or pain let me know and I’ll stop it. At least you’re getting something’.” (RNII)

"I could tell because he agreed, and he said, ‘I like that idea’. Because I don't think he had been given that option. What the nurses had been doing is doing it by the order -- exactly.” (RNIII)

“...he's afraid and he doesn't speak English.” (RNIII)

"It really was such a good experience to see that whole transition and connecting with him. I think just being able to -- that continuative care is such a huge difference.” (RNIII)

Use of Essential Personhood (N=28 inferences or statements made [43.25%])

“--I can't really distinguish that actual moment, but I think I may have been the one to initiate it. Not about-- not bringing her belief or religion into it. I just-- I think I'm the one that brought up like, ‘How can I-- tell me how I can help you’. Like, how can I—‘What can I do for you?’ I think it was more on that level.” (RNI)

Use of essential humanness, or personhood, is a critical part of the way nurses make themselves available to patients (Watson, 2012). Essential humanness, also referred to as therapeutic use of self, can facilitate a turning point in a therapeutic relationship, which may facilitate patient openness. As a conscious experience of both participants, Mutuality evolves over time and allows for the evolution of each toward personal becoming (Henson, 1997; Kayser, et al., 2007; Mendoza, 2012; Watson, 2012). However, Hagerty and Patusky (2003) suggest “nurses and patients do derive positive results from single short-term encounters that are necessitated by shortened hospital stays and are based on brief intervention techniques” (p. 146).

Each respondent inferred her use of personhood in the daily provision of nursing care as evidenced by the following statements from the transcripts:

“He goes, ‘Look, I think I did well eating my meal, don't you think?’ And I looked down I was like, ‘Wow!’ It was a lot. It was half of everything which that was the most that I had seen him eat even since last week. I said, ‘Yes, you did. You ate a lot.’ So I said, ‘We probably don't even need the tube feeding. So that's fine.’ I said, ‘It's up to you if you want it, great. If not, you don't have to.’ So I think he was really comfortable with everything. To me, I felt that was the most powerful to see that patient improve within a week of time. I mean, it would be nicer if it was sooner than that but to see that finally get there, I think was important.” (RNIII)

Connectedness (N=28 inferences or statements made [25.53%])

[Concerning how the RN goes about connecting with patients] “I think both. Sometimes it'll be accidentally when you're not even expecting anything and they might have an a-ha! moment and sometimes you can just try your best and nothing-- to no avail, you know, nothing happens and at other times you can try and it's received and—So I think that connection that you're talking about is a very important concept that I think not everybody have.”(RNI)

Mutuality is labeled a determinant of connectedness within these relationships wherein each participant in the interaction becomes a counterpart in order for a sense of connectedness to happen (DeJesus, 2009; Eaton & Tinsley, 1999; Varcarolis & Halter, 2010; Weaver & Mitcham, 2008).

Researchers McCann & Baker (2001) describe Mutuality as a ‘connected relationship’ characterized by the qualities of openness, self-disclosure, trust, and friendliness. Miller (2008) contends that finding meaningful connectedness helps human beings to encounter all of the vulnerability and risk faced in trying to “change and grow” (p. 114) and stresses “when mutuality is present, it does not mean that sameness or even equality occurs” (p. 115). Rather, what is encompassed within a connected relationship (e.g. qualities such as openness, self-disclosure, trust, & friendliness) (McCann & Baker, 2001) are reciprocal interactions and sharing of feelings like togetherness and equality with the parties simply “fitting each other” (Mårtenson & Fägersköld, 2007, p. 42).

All of the participants emphasized the importance of connection and connectedness with in-patients. Of the terms listed in Chapter 1 that are discussed to be synonymous with Mutuality, “connection” was mentioned by respondents. Cultural considerations (language) are seen in some of their statements from the transcripts:

“I try to connect with all of my patients. I mean, I think most nurses do. We to set up a rapport because to me one of the basic things is you have to establish trust. If you don't have any trust, then it's just gonna be on a professional level.” (RNI)

“I can see the connection with being able to speak the same language with the patient and having the same culture, versus someone who does not speak the same language and them having a harder time being able to, I guess, connect with the patient in that sense.” (RNII)

“But when I speak in his primary language, which is Ilocano, there is more of a connection...I go in there and I ask him his name in that language. And right away, he perked up and he said his name...I was able to get a better idea that he was able to connect with me and communicate because now I'm speaking in his language...every time we told him not to do that in his language he would listen.” (RNIII)

“It really was such a good experience to see that whole transition and connecting with him. I think just being able to have that continuative care is such a huge difference.” (RNIII)

“So I think that connection that you're talking about is a very important concept that I think not everybody have.” (RNIV)

“I think as a nurse you connect with patients a lot of times.” (RNV)

Equity and Reciprocity (N=7 inferences or statements made [17.07%])

“...for someone who’s already having pain, for you to just go ahead and shove all this fluid in there – you really have to meet that individual’s needs. It’s different than everybody else.” (RNIII)

Mutuality is a condition or quality of being mutual. It is also referred to as ‘reciprocity’ and ‘mutual dependence’ (<http://www.dictionary.com>). According to Finke et al. (2008), reciprocal responsiveness elicits a sense of ‘being there’ for another person, not just a physical presence, a nursing skill. This mutual flux (inter-subjectivity) is a dyadic process of thoughts, feelings, and activities which may potentiate gaining power and self-empowerment of each entity within the relationship (Ahlström & Wadensten, 2010; Auslander et al., 2009; Edwards et al., 2006; Kastle et al., 2010; Mendoza, 2012; Munhall, 2007; Nelson, 2000; Piehler & Dishion, 2007; Zoffman & Kirkevold, 2005).

The above-described is important in creating an autonomous and socially responsible nurse who becomes unconstrained in the practice environment (Munhall, 2007). Miller (2008) contends that finding meaningful connectedness helps human beings to encounter all of the vulnerability and risk faced in trying to “change and grow” (p. 114) and stresses “when mutuality is present, it does not mean that sameness or even equality occurs” (p. 115). The seeming difference between reciprocity and Mutuality is that reciprocity is the simultaneous action of sharing whereas Mutuality is a state of relatedness in a reciprocal exchange.

According to the statements below, some of the respondents stressed a stance of being “non-judgmental” and working to “normalize” the patients’ health concerns. As a caveat, there were statements made by three of the six respondents concerning initiating and/or facilitating patient problem-solving that was directly related to the patient’s faith. These faith-based decision making occurrences were directly related to individualized therapeutic management plans.

“I think I respect their privacy. I mean, if they tell me things that they don't want me to say. I'm not talking about, "Oh, I wanna commit suicide." I'm talking about if they say they did drugs before. You know what I mean? I won't hold that against them. You know, if, if they drink alcohol or-- not try to judge them for that. You know what I mean? I, I think I try to-- I think most nurses do. But I-- you know, I try to just establish a trusting relationship with them and it depends on the person. There's no single tactic that I can think of that I use. I mean, I just-- it's all-- the people are different they require different needs. Some people want to be doted on and some people just want to be left alone and I respect that. So, like, if I have a 93-year old that has a sodium level of 126 and she's on fluid restrictions, I'm not gonna lie if she's thirsty I'm gonna give her water. I mean, she's-- you know what I mean? I, I do those little things to-- not to hurt them I'm gonna make sure that they don't have something metabolically wrong of course. But, I mean, I try to make sure that I can do little things like that to make them feel like they might be special in a way, so that they can, I guess, be more comfortable with me. Then I can do my job better.” (RNI)

“I go in there and I ask him his name in that language. And right away, he perked up and he said his name.” (RNIII)

Cultural inflections were not the focus of this study but effort was made to convey the individual nurse's personhood as closely as possible. Watson (2012) postulates a primary focus of nurses' communication when interacting with patients is to influence patients toward better health outcomes through the use of tangible nursing skills (e.g. assessment, health interview, & active listening). That is, if the RN was implementing tangible care in order to connect (e.g. patient teaching, orientation to unit & room routines, the partnered plan of care, or iteration and reiteration of the therapeutic management plan). Some expressions of high-context or a deeper understanding of “connection” from respondents include:

“I can see the connection with being able to speak the same language with the patient and having the same culture, versus someone who does not speak the same language and them having a harder time being able to, I guess, connect with the patient in that sense.” (RNI)

The following are verbalizations of low-context, or literal and concrete skill competencies, relative to tangible nursing care:

“...if they're not sure what's happening to them. And then I'll just sit down, "What are your thoughts? Why are you concerned about the procedure? And sometimes we have a

doctor's order that, "Oh, you need to go to this procedure," but they don't want to do it at the hospital, but they not sure if they trusted that doctor. So they wanted to transfer somewhere else. So we kind of like, okay, sit down with the case manager, and spoke to the family in Oahu, and then they did a research in any of the hospital that they familiar with, and they were able to transfer the next day to whichever doctor they comfortable with." (RNII)

"...explaining most of their plan of care whether they like it or not." (RNIII)

Antithetical Data

Typical behavioral indicators of nurse competency in interpersonal communication related to patient-centered care are discussed in the literature. These include: (a) attempting to understand the situation from the patient's point of view, (b) predicting the patient's actions based on observations, (c) being genuinely interested in the cause of the patient's feelings, thoughts, and behaviors, and (d) effectively reading the patient's unspoken needs or concerns (Zhang, et al., 2001).

It is thought to be possible that when a therapeutic relationship is not established, the likelihood of misinterpretations or non-validated assumptions of 'what the matter is' (patient's health concern) may be made by the nurse. If a connection is not made (disconnection), these misinterpretations and non-validated assumptions may lead to a negative impact on clinical outcomes. This is because erroneous data has been relied on when intervening.

Disconnection/Disconnectedness

The focus this study was not disconnection/disconnected. However, when asked the probe question: "Can you describe a time when connection was not there or when you felt you had connected but the outcomes were adverse?" two of the six respondents inferred occurrences of disconnection and went on to describe resultant adverse clinical outcomes. The following are concerns the RN participants shared about a feeling of being "disconnected" or "disconnection" with patients:

"But if you don't connect with them, you cannot push them forward, you don't push them forward, they don't get out of here, they stay in the hospital, they have complications.

And it's just not a happy picture." (RNIV)

"When I don't feel like I'm connecting with the patient, I feel like I'm just robotically doing things. Give the meds, go on to the next one, give the med -- and you're not making that connection where they can trust you and you can move them forward and get them out and go home." (RNV)

Adverse Clinical Outcomes

Just as the development of a therapeutic relationship between a nurse and a patient is thought to be a consistent predictor of positive outcomes in therapy (Edwards, et al., 2006), the negative properties of *mutual avoidance*, alienation, and/or indifference between the nurse-patient dyad may result in adverse clinical outcomes. The following statements fit the aforementioned assumptions:

"...he continually refused his tube feeding-- refused, I mean really poor PO intake." (RNII)

"...sometimes we have a doctor's order that, 'Oh, you need to go to this procedure,' but they don't want to do it at the hospital, but they not sure if they trusted that doctor. So they wanted to transfer somewhere else. So we kind of like, okay, sit down with the case manager, and spoke to the family in O'ahu, and then they did a research in any of the hospital that they familiar with, and they were able to transfer the next day to whichever doctor they comfortable with." (RNII)

"Had they put me in the back, I wouldn't have been able -- who knew if there was a new nurse that didn't know what happened from before and how to work with him." (RNII)

"...then the other lady who we didn't invest as much time and energy on, she'd ended up getting the complications, she had a little bit of pneumonia, atelectasis, and then they get a little bit fever and it's just one thing after the other." (RNIV)

"...we had one patient who had a reversal colostomy. And he didn't want to get out of bed. It was post-op day four. He's supposed to be walking in the room already, but because he didn't want to get out of bed because he was sore and I think afraid, you sense that. The other nurses were okay to just let him stay in the bed." (RNIV)

"Because if not -- like I told him, 'If you stay in bed, you're gonna get pneumonia, you're not gonna breathe better, you could go in a-- not sleep as good. You need to push things along. You're gonna get distended, you're gonna get nauseated, and we're gonna have to put an NG tube in your nose and we're going to get all these complications. You're gonna get bed sores.' And I told him, 'your hands' -- and this is what I tell all my patients. 'Your stomach had the surgery. But your fingers and toes and legs and arms did not have

surgery.' So even if he's in the bed, every time he watches a commercial, he should be exercising his fingers, he should be exercising his wrists, he should be moving his arms and reach for the ceiling. Then on the next set of commercials, he should be moving his toes, he should move in his ankle, he should be moving his knees and then bring his leg up. Yes, he had the surgery but he can splint, he can move the leg up. So that when we get him up, he's tense. But instead, he stays in his paralyzed position, afraid that he's going to hurt something more, he's afraid. And I think, um, everybody who was before him, it's just-- it's overwhelming. I don't know if, um, you know, you have tasks to be done and, um, you cannot invest the time or they had-- don't have the connection." (RNIV)

"They're lying in that bed and they feel so overwhelmed. And they don't know any better. They're not educated. You are the nurse, you're educated so that particular nurse who's coming on board with a preceptor... I told them -- so the next day, I told them, 'How much did that patient walk for you?' And she says, 'Oh, he doesn't want to walk. He's refusing.' So she's coming on the other scope of practice of (patient rights), 'If they're refusing, I cannot push them because that's abuse.' But I told her, 'That's not abuse.'" (RNIV)

"...the high risk, the way I explained to her that, "If you're not going to have this (procedure), you're probably going to having more complications...because she's nearly passing out every time and she just doesn't want to do it (procedure). And every day I have her, her (test) keep on going down to the point that I thought she nearly passed out in the bathroom." (RNV)

Non-Verbal Communication

Following each interview, the PI immediately notated the non-verbal expressions of each respondent. Predominantly, the respondents maintained an open posture, leaned into the discussion, and repeatedly smiled throughout the interview; especially when the focus of thought-sharing was on "connection", "a powerful story", or individual-specific styles and approaches. Notable was the change in countenance each respondent assumed when asked about "disconnection" with patients. Some respondents lowered their voice volumes, looked downcast, or even sheepish or ashamed when relating a story about feeling unable to connect or "losing connection."

Inferential Communication

Premises concerning Mutuality in a caring moment between the respondents and patients were made by four out of the six respondents (e.g. described shifts occurring within the

relationship). These premises were evident through verbal and non-verbal communication and demonstrated occurrences of Mutuality being achieved (see below description of Convergence).

Unanticipated Data

Throughout the data analysis by the PI it became apparent that certain RN participant statements form a higher order of what appeared to be phenomenological patterns. These patterns are seen as the final dimension of the data analysis and are organized in the following way:

- Joy in Privileged Access
- Personal Satisfaction of Self-Efficacy
- Togetherness
- Energy Exchange between Nurse-Patient
- Transformative/Transitional Happenings

Joy in Privileged Access

Beck (2001) claims that a dyadic caring interaction can foster uplifting effects for persons involved. That is, feelings of being respected, of belonging, of personal growth and transformation among nurses who want to learn to care and to provide care (Ahlström & Wadensten, 2010; Auslander et al., 2009; Beck, 2001; Curley, 1997; Henson, 1997; Kasle et al., 2010; Mendoza, 2012; Nelson, 2000).

Today, Cowling and Chinn (2001), suggest that in using a unitary perspective (oneness) lens “as a means of viewing, seeking, and envisioning human life and possibilities,” (p. 368) nurses can gain insight into a patient’s reality within the situated context of a health crisis. This includes unconditional acceptance of patients as they are.

Three of the six RN respondents inferred a sense of joy in having privileged access to patients as seen in the following remarks:

“I get a chance to communicate with patients, especially family at the bedside.” (RNI)

“I got to take care of him for three days.” (RNIII)

“I think that's really important for that continuity of care. So, for me to be able to even know him already from how he was last week to his progress this week, I think it was such an awesome experience!” (RNIII)

“I think the awesome part was, the last day that I worked with him-- so it was like three days in a row.” (RNVI)

Personal Satisfaction in Self-Efficacy

Sherwood (2012) suggests a human factor to consider is how nurses exact the tasks of relating to and communicating with patients. She states, “quality is an inherent approach to doing good work” and that “nurses come to work wanting to perform good work but they sometimes lack the preparation and tools or may work in systems where good work is not recognized or important” (p 16).

Day and Smith (2007) portend that nurses demonstrate effective communication when root causes of patient health problems are identified and addressed. This becomes evident when nurses ask, “What is the most important thing to do right now for this patient?” In answer to this, nursing researchers iterate that “When we ‘act for others’, we need to know both what the other wants and what we are willing to do and to have strategies for negotiating between those desires” (Shirley, 2007, as cited by Hood, 2010, p. 17).

To discover what patients want or need, nurses intentionally strive to connect with them through respect of personhood. As a result of this depth of connection, openness may be fostered and individualized nursing care enhanced (Chinn & Wheeler, 1985). The following statements made by the RN respondents are evidence of a personal sense of satisfaction with “being a better nurse” and the skill of “seizing the opportunity” to be effective:

“I think that was just an opportunity for her to talk about it and I jumped on it. You know what I mean? It was in the middle of the night. There wasn't really anything I could do but there was something I could do. I could order the blood 'cause there was a standing order.” (RNI)

"I love it when I am able to see a change in a patient and see that they are feeling so much better knowing that they're fighting cancer and all you hear them saying is that they're in

pain, they're in pain and just yesterday he was saying he has zero to maybe like one out of 10 pain level.” (RNI)

“For that person who, for me, if my patient has one good day or that one moment of clarity where-- if they're able to accept their destiny I think the family shouldn't be the one to hold 'em back. You know what I mean? You know how they go through those stages. See once they get to that acceptance that the family should-- and I say that because it's a huge thing. I never realized it. On night shift you don't really see that but working on day shift, I mean, the family is a significant part...” (RNI)

“Because, it allows me to do my job better. It allows me to do my job better because if I can establish a personal relationship I think I can do my job as a nurse, 'cause as a nurse I feel like I'm a liaison between the doctor and the patient. And if I don't have that relationship with that patient, it's hard for me to be a liaison because I don't know exactly what the patient wants. I don't know if the patient is doing it because that's what the doctor is saying to do or what the family is doing. I want to do what the patient wants to do.” (RNI)

“I think on the night shift when the family is away and you have more time to be more of a friend, I guess, I don't know friend is a word instead of a nurse because you don't have all that responsibilities that you have during the day. It's just a quieter time. I think. I know a lot of times the patients they're not afraid to speak for themselves. 'Cause during the day they're kinda-- the family is guiding what they're gonna say. You know, they wanna adhere to what the family wishes are and they don't really tell you what they want.” (RNI)

“I think that's really important for that continuity of care. So, for me to be able to even know him already how he was last week to his progress this week, I think it was such an awesome experience.” (RNIII)

“...I was able to get a better idea that he was able to connect with me and communicate because now I'm speaking in his language. He was smiling throughout the day. I was able to pretty much provide better care and able to communicate with him...” (RNIII)

“I was able to pretty much provide better care...I would continue to try to encourage him.” (RNIII)

“...it was nice to see...I went in there and I talked to him and I said, "How are you feeling?" He's like, "I feel 100% better." And I was like, "Really?" He said, "Yes," and he looked better.” (RNV)

Togetherness

Mutuality is seen as an element of healthy relationships (Erickson, 1968; Wynne, 1984 as cited by Henson 1997). What is encompassed within a connected relationship (e.g. qualities

such as openness, self-disclosure, trust, & friendliness) (McCann & Baker, 2001) are reciprocal interactions and sharing of feelings like togetherness and equality with the parties simply “fitting each other” (Mårtenson & Fägersköld, 2007, p. 42). This aim of developing a sense of “togetherness” or “working together” was verbalized by many of the RNs respondents in the statements below:

"I'll work with you...He appreciated that intervention; that I'm working with him, and trying to do all these different approaches --..."(RNIII)

“‘Together piece’ meaning like, you know, I explain the plan of care for today and she agrees so we kinda connect. And I guess with her... how would I say? Like she trusted me.” (RNIII)

"Yeah, and it's throughout my career. You know, this is like way back and that's where I formulated this idea of nursing where you've got to get “up together”...it's a joint effort, 'Let's do it together,' so they don't feel so afraid and alone. To me, that's it. We had two patients that [sic] had hysterectomies back in the '80s. And I was a new grad but I'd seen where one-- they were both the same age and both of them were abdominal hysterectomies. And um, one refused to get out of bed. The lady re-- adamantly refused to get out of bed. She didn't want to get out of bed. She didn't want to get out of bed. And at that time, we had 1 to 15 patients, 1 RN to 15 patients. And so, you pass your meds, you came back around, you pass the second set of meds, you know? But [name] was my LPN that time and we needed to get these ladies out of bed but the one-- so we grabbed the one lady and she came with us and she cried. She cried in the hallway. It was so sore; it was so painful. But we pre-medicated her, we did it, but I think a lot of it is frightened. They're frightened because they're sore." (RNIV)

"And here I come on day four, and I told him, 'No, you got to get out of bed. Let's do it together.' And I think because you throw all your energies to give to them, and they grab that energy and they psyche themselves up, 'Okay. I got to get out of bed.' And ultimately, I didn't give him an option to not get out of bed. And I said, 'I'm not going to go home. I'm gonna have to stay here until we get you up.' And it wasn't to get up and go walk, but just make baby steps. I told him just, 'Why don't we just sit up and dangle at the bedside?'" (RNIV)

“...but if you tell them, 'Let's do it together,' I think they're less afraid, they're less-- their anxiety goes down and then you can get them up together because it's not a, 'Sure. Okay. You will get up out of bed. You need to get out of bed.' But it's, 'Let's do it together.' I don't know..." (RNIV)

Energy Exchange between Nurse-Patient

The art of manifesting intention and using deliberateness in the provision of nursing care reflects consciousness, “a meaningful energetic blueprint for transformation” (Watson, 2008, p. 360). Some of the RNs touched on energy exchanges between themselves and the patients as made apparent in the following remarks:

“You can see he's a little bit more light -- and I mean, more glowy.” (RNI)

“I think taking the time and energy and connecting with the patient and them trusting you is so important. And that's why I think I, um, I told [name], 'When I go home, I feel just so exhausted because you throw in all this energy and I don't like to get major projects before I go to work because I don't want to go work tired. Because if I go work tired, I don't feel like that same concept...’ (RNI).

"And here I come on day four, and I told him, 'No, you got to get out of bed. Let's do it together.' And I think because you throw all your energies to give to them, and they grab that energy and they psyche themselves up, 'Okay. I got to get out of bed.' And ultimately, I didn't give him an option to not get out of bed. And I said, 'I'm not going to go home. I'm gonna have to stay here until we get you up.' And it wasn't to get up and go walk, but just make baby steps. I told him just, 'Why don't we just sit up and dangle at the bedside?'" (RNIII)

“...let me just kind of reach back on what my philosophy over the last 30 years I feel. Like I think, um, the patients grab your energy and, um, that's why I don't like to go work tired. And I think that's why I come home so exhausted.” (RNIV)

“...but it takes energy and it takes time and...they pull off your energy.” (RNIV)

Transformative/Transitional Happenings

As discussed in Chapter 1, a later study of the Theory of Human Relatedness, Hagerty et al. (1993) defined Mutuality as “the experience of real or symbolic shared commonalities of visions, goals, sentiments are characteristics, including shared acceptance of differences, which validates the person’s worldview” (p. 208).

Another consideration pertaining to the use of self is that interdependence and influence in the relationships with others and a view of self becomes transformative (Hedelin & Jonsson, 2003). This will give context to their everyday work-based lives and how perceptions of their

interactions with patients are linked to this social competency. This is of particular interest in generating new nursing knowledge and identifying ways to promote patient safety and improve clinical outcomes.

The following statements by the RN participants are reflective of the afore-described concerning transformative happenings:

“...so I'm not saying that I changed the course because he subsequently passed but we were able to get him admitted into ‘Comfort Care’. And, you know, they were a little open to the hospice and...It was me solely but, you know, I think it was that eye-opening moment and I thought it was powerful because I believe that people should pass with dignity. I mean, people should be able to maintain their dignity to the very bitter end. You know what I mean? They shouldn't have to continue treatment. It's not the family's battle, it's the patient's battle, I think. You know.” (RNI)

“I might be onto something then I roll with it. You know what I mean? It's always a different situation. And that story that I just told you I mean it's something that I think a lot of the nurses do. You know what I mean? Like, we all have little stories that we can tell and we're always gonna remember those significant moments and remember those life changing moments and...” (RNI)

"Yeah, but these Filipino families kind of -- you know how they don't want to talk to other people, so she became more comfortable with me that I speak her dialect, and then I had her for the next three days, stuff like that. So, yeah. And after so many months she came back, and said, "Oh, I'm doing good [laughter]...you can feel that relaxation.” (RNII)

"It really was such a good experience to see that whole transition and connecting with him. I think just being able to have that continuative care is such a huge difference.” (RNIII)

"I love it when I am able to see a change in a patient and see that they are feeling so much better knowing that they're fighting cancer and all you hear them saying is that they're in pain, they're in pain and just yesterday he was saying he has zero to maybe like one out of 10 pain level.” (RNIII)

Hood (2010) states “when the nurse is deliberate and purposeful in establishing a level of communication with a client which promotes client openness (i.e. disclosing information, needs, & expectations) the client’s health needs are more likely to be met” (p. 471). Implicit is that Mutuality in communication must exist between nurse-client and may serve as a catalyst to

trigger client openness.

Convergence

Nelson (2000) postulates that at an intersection of two processes of pure experience, the patient's and the nurse's, Mutuality occurs. Hence, they participate nearly equally rather than nurse dominant. The association to connectedness can be counted as belonging to two different lived experiences intersecting (Nelson, 2000) and that intersecting manifesting as Mutuality. As a result of a caring event (Point of Intersection) appears to change when the nurse works to understand what is more or less important in the delivery of nursing care. The nurse who consistently gets to the "heart of the matter becomes proficient in attuning to and recognizing nuances. What is assumed now is that *convergence* appears to occur at that Point of Intersection (see Fig. 5 at the 'Bull's-Eye' point).

For the purpose of this data analysis, convergence may be defined as social construct in which similarities between the nurse and patient converge as a result of the environment fostered by the nurse. Specifically, within this fostered environment, a transformation in the therapeutic relationship between a nurse and a patient is manifested and Mutuality is attained.

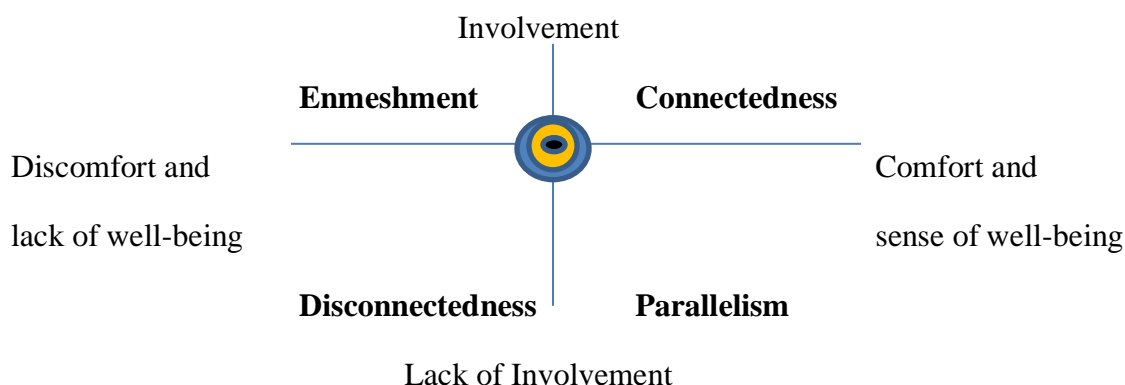


Figure 5. Convergence at Point of Intersection of States of Relatedness Axiom

(Adapted from Hagerty et al., 1993)

Discussion

The findings show the respondents' skills of engagement and involvement. These skills seem to improve on the basis of the RN being open and attentive in order to act in an effective manner. That is, connecting with the patient's experience and the logic necessary to do so. Perception and insight are opened and both count as being therapeutic. "The ethical comportment of individualized care has to do with the RNs connecting with and understanding the patient's experience through engaged thinking. A sense of, 'It matters to me what's going on with you' is visible. Essentially, RNs confronting suffering, vulnerability, and helplessness puts meaning to the patient's lived experience" (Tiptiklis, 2005 as cited by Benner, 2005) of a health crisis or concern.

Summary

A descriptive analysis of the exploratory interviews predominantly revealed the RNs' lived experiences in achieving Mutuality through connection. The data was useful in two ways: The expression of key aspects of Mutuality and the constellations of themes (see Table 3). Verbal data supported what was stated and inferred. The only finding that was evident in non-verbal data was an obvious change in a respondent's countenance. During each RN's storytelling concerning her experiences of connection, an open posture was maintained, hand gestures and animations were made, and an upbeat tone of voice was kept. However, when each RN respondent discussed her experiences concerning a lack of connection (disconnection), there was a noticeable shift in demeanor as each assumed a closed-posture and downcast appearance.

An issue for further research is to examine how transition or transformation are achieved using Mutuality is within the nurse-patient relationship. There is also a need to further examine the RN counterparts (patient) perceptions and if patients have similar positive experiences during encounters with RNs.

CHAPTER 5

“It made me that much of a better nurse for that patient because of that experience. So, having that connection that you've worked with him last week and he recognized me and being able to take care of him for three days in a row and seeing that improvement was awesome. To me, I feel like, ‘Okay, this is how nursing should be. To be able to see and to be able to really know that you made a difference in this patient while they were here. And not just you're in and out, in and out. Which a lot of times you don't have time to go in there and talk to them, but I think that because of the fact that we don't have the time to really spend with our patients as much as we want to now with acuities being – could be up to six patients and it's constant discharging patients and admitting patients. It's like you have to take care of them for three to four days to be able to get that whole picture and be able to provide that care as if you had only one patient a day to be able to spend time with them in those amount of hours, you know? To kind of add up to it. But it was really – to me, I felt that was just awesome to see before I leave that day and – because I'm going to be gone for the next three days before I come back to work and who knows if he's going to get discharged and not for me to see that change in his care and know that he's feeling better, that was – to me, I was like, "That's nursing," you know?" (RNIII)

INTRODUCTION

In this final chapter, the results from the study are summarized and plausibility discussed. Mutuality, as a social competency and new way of communicating, was selected as the focus area for study as it may impact patient safety and positive clinical outcomes. Additionally, the nursing Theory of Human Relatedness (Hagerty et al., 1993) is used as a unifying theory for these pursuits. Participant comments are provided in terms of what have appeared as emergent properties (i.e. newly-discovered aspects) of Mutuality. Finally, the limitations of the study and directions for the future are presented.

Summary of Study

Ways nurses can establish and strengthen therapeutic relationships in order to promote patient safety and to improve clinical outcomes through improved communication approaches were studied. This is important because a high level of dedication to doing a good job, and

deliberately striving to relate to patients through skill development, may strengthen the quality of helping relationships (i.e. connectedness).

Although a major focus of this study was not on an improved communication approach, issues of safety and efficacy came up between four of the six respondents (see Chapter 4 in the Adverse Clinical Outcomes section). Codier and Codier (2017) suggest that “the experience of being cared for can impact safety...as safe health care depends on accurate information” (p. 61). Given these premises, it makes sense to focus attention on mitigating nurses’ reliance on erroneous data or assumptions by employing the use of Mutuality in therapeutic relationships with patients.

To help sharpen the focus in studying related research, education, and clinical practice concerning how nurses relate to patients in clinical practice, the Theory of Human Relatedness (THR) was used as the most appropriate framework to use. Husserl’s phenomenological approach was used as a method for comprehending the essence of a lived experience of Mutuality in real situations encountered within the nurse-patient relationship.

According to Finke et al. (2008), reciprocal responsiveness elicits a sense of ‘being there’ for another person, not just a physical presence, but an advanced nursing skill. This mutual flux (inter-subjectivity) is a dyadic process of thoughts, feelings, and activities which may potentiate gaining power and self-empowerment of each entity within the relationship (Ahlström & Wadensten, 2010; Auslander et al., 2009; Edwards et al., 2006; Kasle et al., 2010; Mendoza, 2012; Munhall, 2007; Nelson, 2000; Piehler & Dishion, 2007; Zoffman & Kirkevold, 2005).

The level of involvement with patients, the relationship between speech, and a focus on the aspects of speech that bear directly on the specific aims of the study were deliberated. That is, the key aspects (social competencies) of Mutuality were explored, the relationships between

those key aspects, if any, were discovered, and the limitations of the basic data were taken into consideration (Lindlof, 1995).

The analysis process was cyclical regarding data-text translations, coding, and conceptualizing using a thematic framework. The mode of transcription and comparative analysis process adopted reflect sensitivity to THR. This was ideal in that not much is previously known about the concept under investigation within nurse-patient dyads. Also, the mistake of reaching closure prematurely was avoided as it is understood that validity is an issue in qualitative research. This is because of the danger of the PI imposing her own unwarranted personal definitions on what was observed (Lindlof, 1995).

The researcher began to look for indicators of the key aspects of Mutuality, a state of relatedness, which were identified as relevant at the start of the study and assumes they are still relevant at this point.

Conclusions

As discussed in Chapter 4, data was categorized and organized into theme clusters and themes. In this process, it was ascertained whether or not the RN experienced a seeming change in beliefs and/or behaviors (paradigm shifting) and if there were resultant increases in confidence and skill development. Conclusions were drawn concerning any relevant discussions of the ethic of caring.

Limitations

Overall, there were too few participants to generalize the utility of Mutuality as a strategy for achieving connectedness in nurse-patient relationships. Also, there were only two nursing units included in the study whereas in order to fully inform Mutuality additional interviews of RNs serving in a variety of clinical settings is needed. In addition, a significant factor missing in the study of Mutuality is the perceptions of the patient, as a counterpart in the nurse-patient

relationship, since the focus of this study was entirely on the nurse counterpart. It would be helpful in gaining a deeper understanding of the use of Mutuality if exemplars were drafted and considered as embodiments of an inductive constructs because without exemplars, the claims made would be empty and unpersuasive (Lindlof, 1995). An abbreviated exemplar (story) could be introduced for each key aspect of the concept of Mutuality with the aim of finding solutions and news strategies for nurses to connect with patients.

Recommendations for Further Study

There are four recommendations for further study which evolved out of the data analysis:

- 1) Implications for nursing education and development of the nursing workforce concerning the utilization of Mutuality as a nursing intervention strategy.
- 2) Development of a psychometric tool to measure the existence of Mutuality within nurse-patient relationships.
- 3) Exploring patients' perceptions of "connectedness/disconnectedness" within the nurse-patient dyad.
- 4) Interviewing a target group of RNs who depict the typical profile demographics in the State of Hawai`i.

Implications for Nursing and Development of the Nursing Workforce

It is thought that through nursing workforce development in establishing therapeutic relationships with patients, nurses can more accurately identify health problems, promote patient safety, and improve clinical outcomes (Sherwood, 2012) by reflecting on how they communicate with patients. Hence, nurses are charged with establishing therapeutic relationships by engaging patients through the use of effective communication while bearing the responsibility of fulfilling a helper role.

Development of a Psychometric Tool

Although Tantillo and Sanftner (2010) developed the *Connectedness-Disconnectedness Scale (CDS)* used in psychometric testing to measure *perceived mutuality* in interpersonal relationships of women with eating disorders in a study conducted in 2008 (see Chapter 1). This is another example of an instrument used to measure the presence of Mutuality in therapeutic relationships, but the context differs in that: (a) Mutuality is still not measured within a nurse-patient relationship and (b) the aforementioned measurements are of the relationship between a patient and a disorder or ailment [physicality] and significant others, not a nurse. Future research will include exploring if the CDS can be adapted for future use in measuring Mutuality in the nurse-patient relationship specific to communicative processes.

Exploring Patients' Perceptions

If a key aspect of Mutuality is equity, then it makes sense to explore patients' perceptions within the nature of that dyad as the RN counterpart. Therefore, the next phase in studying Mutuality within the nurse-patient relationship is to gain an understanding of the patient's perceptions of "connectedness/disconnectedness". To date, those perceptions are absent in the nursing and psychosocial literature. Also absent are any determinants associated implications, specifically, the quality of clinical outcomes.

The PI focused on the nurse-patient dyad and partnership within that relationship. However, through the data analysis, this premise became apparent: While the onus of establishing a therapeutic relationship lies solely with the nurse, the findings in this study elucidate establishing rapport is a shared responsibility between nurse and patient.

Target Group Selection

According to Minkler and Wallerstein (2008), "participatory research is critical for practical problem solving through a cyclical process of fact finding, action, and evaluation" (p. 9). Therefore, it is essential that a target group that is representative of the demographics

in the locale be maintained in order to achieve a balance between research and action.

Summary

With the advent of caring-healing practice environments progressively dependent on partnership models, negotiation, and coordination, Mutuality may be employed as a practice intervention. This study showed that nurses are in a critical position to transform therapeutic relationships with patients. Therefore, it makes sense that development of partnership models within nurse-patient relationships, and new forms of communication, could transform self-efficacy and clinical outcomes.

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APPENDIX A

Consent Form

Agreement to Participate in
“The Study of the Lived Experience of a Caring Moment of Mutuality between
the Nurse and Patient in an Acute Care Setting
University of Hawai‘i at Mānoa School of Nursing and Dental Hygiene
Online PhD in Nursing Program
Honolulu, Hawai‘i 96822

The Principal Investigator (PI) of this study is Julie Potter-Dunlop and can be contacted at 808.984.3455 or via e-mail at jpotterd@hawaii.edu concerning any questions or concerns you may have regarding the project procedures. The PI's PhD Advisor is Dr. Estelle Codier, Associate Professor at University of Hawai‘i at Mānoa School of Nursing and Dental Hygiene. Dr. Codier can be reached by e-mail at codier@hawaii.edu or calling 808.783.1583.

This project is being done in partial fulfillment of my doctoral degree. Interviews are being done as a part of a study of the concept of Mutuality in the nurse-patient relationship. The purpose of this study is to examine your perception of connection in the event of a caring moment between you and a patient in an acute care (hospital) setting. **For the purpose of this study, Mutuality is defined as the way in which you connect with a patient in a therapeutic relationship.**

With your permission, I will conduct one or two 30 to 45-minute audio-recorded interview sessions with you, each at a separate time that we agree upon on the MMMC campus and before/after your assigned work shift. I am also asking that you complete the attached RN Data Sheet for use in describing the target population (RNs). The RN Data Sheet will be absent of any participant identifier (e.g. your name or data collected on the form) and coded in such a way that the information will not be correlated with any audio-recording.

Should you disagree with being audio-recorded and/or completing the RN Data Sheet, you are indicating that you do not wish to participate in this study. All audio-recordings and RN Data Sheets will be securely locked in a file cabinet in the Principal Investigator's office with the office door being locked as well.

A psychological risk to you may include personal feelings of distress when sharing your thoughts or feelings during the interviewing process. However, you will not be made to feel inadequate or negligent based on your responses in the interview. Counseling services will be made available to you by a trained Social Worker in the Maui Memorial Medical Center's Social Work Department. Additionally, a benefit to you may include gaining insight and knowledge into the manner in which you connect with a patient in a therapeutic relationship.

Your participation in this project is completely voluntary and you may withdraw from participating at any time. You may elect not to answer my question(s) at any time for any reason. The interviews will be informal and in a question-response way. Following the interview, the audio-recording will be heard (only by me) and your responses to my questions will be written

down and reviewed. I will then return the written comments to you so that you will be given the opportunity to read the written responses to the questions and make any corrections or changes you wish. I will then put your comments into the written document, and at a later date, will complete the document. If you disapprove of your comments as written, or what I have explained above, I will destroy the digital audio-recording and throw away the written document with your comments, and your participation in this project will end.

At the end of the project, the audio-recordings will be erased. Your written responses to my questions may be used for publication in the future. **Your name will not appear on any document and your interview will be coded in a way that you will not be identified as a participant in the project.**

"I agree that I have read the above and I understand what was explained to me about this research project. I have been given satisfactory answers to my questions concerning the project procedures and audio-recording. (Check one) I ☐ Agree or ☐ Disagree with having my verbal responses or comments audio-recorded. Expressing that I disagree with having my verbal responses or comments audio-recorded indicates that I do not wish to participate in this study. I have been advised that I am free to withdraw my consent and to discontinue participation in the project at any time without prejudice.

I give my consent to participate with an understanding that my identity will remain anonymous in this project. I also understand that consenting to participate in the study does not waive any of my legal rights, nor does it release the Principal Investigator or the institution or any employee or agent thereof from liability for negligence"

Printed Name

Signature of Interviewee

Date

This consent form and the RN Data Sheet are being collected at the end of this meeting. If you have any questions regarding this project, please contact Julie A. Potter-Dunlop, the Principal Investigator (PI) of the study at 808.984.3455 or by e-mail at jpotterd@hawaii.edu. The PI's PhD Advisor is Dr. Estelle Codier, RN, MSN, PhD, Associate Professor at University of Hawai'i at Mānoa School of Nursing and Dental Hygiene. Dr. Codier can be reached at 808.783.1583 or by e-mail at codier@hawaii.edu.

If you cannot obtain satisfactory answers to your questions, or have comments or complaints about your treatment in this study, contact: Committee on Human Studies, University of Hawai'i at Mānoa, 2540 Maile Way, Honolulu, Hawai'i 96822. Telephone: 808.956.5007

APPENDIX B

RN Data Sheet

Demographic Data of Registered Nurse Participant

Code: _____

Age: _____

Gender: M / F

Other: _____

Employment status: Part-time _____

Full-time _____

Ethnicity: African-American _____

Asian _____

Caucasian _____

Hispanic _____

Pacific Islander _____

Native Hawaiian _____

Other _____

Primary Language Spoken (as identified by Registered Nurse) _____

Highest Level of Education: Diploma _____

AA/AD _____

BSN _____

MSN _____

Doctorate _____

Number of Years as a Practicing Registered Nurse [Write-in]: _____

APPENDIX C

Colaizzi's (1978) Nine-Step Process in Comparative Data Analysis Method

1. Describe the phenomenon of interest.
2. Collect participants' descriptions of the phenomenon.
3. Read all participants' descriptions of the phenomenon. All oral or written descriptions are read in order to obtain a feel for the whole. Significant statements and phrases pertaining directly to the phenomenon are extracted. Significant statements are summarized and restated using participants' language. Meanings are formulated from these significant statements and phrases. Meanings are clustered into themes (Kim, 2014; Munhall, 1994).
4. Return to the original transcripts and extract significant statements.
5. Try to spell out the meaning of each significant statement.
6. Organize the aggregate formalized meanings into clusters of themes.
7. Write an exhaustive description.
8. Return the original transcripts to the participants for validation of the description (member-check technique).
9. If new data areas are revealed during the validation, incorporate them into the exhaustive description. Any additional new data is incorporated into the fundamental structure of the experience" (Kim, 2014; Munhall, 1994; Streubert & Rinaldi-Carpenter, 2011).